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ABSTRACT

This ERIC information analysis paper provides high school debaters and their teachers with guidelines for research on the debate resolutions selected by the National University Extension Association's Committee on Discussion and Debate. Focusing on the problem of health care of U.S. citizens, the material included in this paper is divided into five sections: (1) definitions, including the problem area and the three potential propositions; (2) present structures, including brief remarks about the many approaches which exist regarding care for citizens; (3) problems, with some of the directions teams might consider for developing cases on the propositions; (4) solutions, noting a few of the approaches implied by the propositions, as well as the difficulties which such policies might encounter; and (5) bibliography, including a selected set of potential reading for students working on this topic area. This guide to issues and resources is also intended for use by educators in planning debate workshops or in teaching students about the processes of research in argumentation. (LL)

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ERIC First Analysis:
1977-78 National High School Debate Resolutions

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Contents

Foreword

The *ERIC First Analysis* of the 1977-78 National High School Debate Resolutions was prepared by the author for publication by the Speech Communication Association in cooperation with the Educational Resources Information Center Clearinghouse on Reading and Communication Skills. (ERIC/RCS)

The *ERIC First Analysis*, published annually since 1973, provides debaters with guidelines for research on the debate resolutions selected by the National University Extension Association's Committee on Discussion and Debate. This year the resolutions center on the problem of health care for U.S. citizens. Through study of the author's analysis, students should gain insight into the breadth and depth of the issues involved in the debate resolutions. Educators will also find the resources useful in planning debate workshops or in teaching students about the processes of research in argumentation. Individuals studying the problems of health care in contexts other than debate will also find the *Analysis* to be a valuable guide to issues and resources.

This project fulfills the directive from the National Institute of Education (NIE) that ERIC provide educators with opportunities for knowledge utilization beyond that provided by the ERIC data base. NIE, recognizing the gap between educational research and classroom teaching, has charged ERIC to go beyond its initial function of gathering, evaluating, indexing, and disseminating information to a significant new service—commissioning from recognized authorities information analysis papers focusing on concrete educational needs.

As an ERIC information analysis paper, this one has two unique features: (1) it is intended for direct use by high school students as well as by their teachers; (2) it must be written in the space of one month after announcement of the national debate topic (on February 1). The author's thorough analysis of issues and sources in so short a time and his adaptation to the needs of high school debaters are tributes to his excellence as a forensics educator.

Barbara Lieb-Brilhart
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Director, ERIC/RCS

National High School Problem Area 1977-78

How can the health care of United States citizens best be improved?

Debate Propositions

Resolved: That the federal government should guarantee comprehensive medical care for all citizens in the United States.

Resolved: That the federal government should establish a national program of malpractice insurance for all health care professionals.

Resolved: That the federal government should establish a comprehensive program to regulate the health care system in the United States.

Introduction

The source and quality of health care for citizens of the United States will remain an arguable question until citizens quit worrying about their health. As high school debaters and coaches begin their preparations to debate the 1977 topic, they may find the following analysis helpful in pointing out some of the questions which should be given consideration. But the answers to the questions will be found only through continued research and analysis by debaters. For the essence of argument, one must look first to the interaction between the analyst and the problem, and then to the actual clash between advocates.

The material below is organized into five sections: (1) *definitions*, including the problem area and the three potential propositions; (2) *present structures*, including brief remarks about the many approaches which exist regarding care for our citizens; (3) *problems*, with some of the directions teams might consider for developing cases on the propositions; (4) *solutions*, noting a few of the approaches implied by the propositions as well as the difficulties which such policies might encounter; and (5) *bibliography*, including a selected set of potential reading for students working on this topic area.

How can this material best serve the individual? The writer assumes that his readers are *debaters*, beginning their preparation for the 1977 debate topic. Even without prior debate training, a student should read through the material rapidly, and return to specific segments afterwards for further consideration. The beginning debater will notice unfamiliar terms and concepts used within the text. Others, more familiar with the debate activity, can clarify these terms. Hopefully, instructors can employ portions of this text in discussions of theoretical concepts of argumentation.

No work of this type can be done without substantial help from others. Members of the advanced argumentation class at the University of Houston dedicated uncounted hours to the development of their "specialties" for this analysis. Most of the research is theirs; even language of the units in some cases. They are, in a real sense, co-authors of this preliminary analysis. Their names (and specialties) are James R. Hobbs (medical cost), Sheleigh Carnichael (Medicare), Ina Schwartz (medical research), Tim Cappolino (preventative care), Randy Beck (Medicaid), Clay A. Merchant (malpractice), David Spofford (HMOs), Bridgett A. Brown (mental health), Cheryl Gillum (veterans benefits), Joy Cowen (drugs), Ted Isensee (group health programs), Margaret Dudar (Hill-Burton), and Judy Sands (federal health care perspectives). David Burton and Darryl Carter, two current University of Houston debaters, also assisted with some details and bibliographic work.

Special acknowledgment is due to Dr. Lucy Keele, California State University at Fullerton, for her continued support and encouragement in this project. Barbara Lieb-Brilhart, Linda Reed, and Dorcas Rohn worked in the editing of this analysis. Whatever errors persist are the writer's fault, not the editors'.

To produce this analysis within one month meant shortcuts were necessary. There are probably errors of fact and judgment incorporated herein. The reader is cautioned to *check the references*, a piece of advice given to this writer in 1950 and equally valuable today.

This work is dedicated to my high school coach, Fern Reed Smith, of Camarillo, California (nee Britton, Oklahoma).

The Overall Problem Area

The problem area to be discussed this year is *How can the health care of United States citizens best be improved?* Selected by a vote of the several state and national debate leagues, this problem area stimulated the Advisory Council of the National University Extension Association (NUEA) to formulate three propositions, one of which will be the national high school debate topic for 1977.

At the December 1976 meeting, the NUEA Advisory Council confirmed that "interpretation of debate resolutions should be within the context of the overall problem area."[1] This action is consistent with actions taken by the collegiate topic wording committee, which currently distributes a "Parameters of the Topic Statement" along with the balloting procedure for college debate coaches. If this policy position influences judges, the debaters should respond to the implications. For that reason, the following analysis of the overall problem area is included.

Two comments are necessary here regarding the implications of the judgment of the NUEA Advisory Council: (1) the confirmation employs the word "should" rather than a stronger word, such as "must," and (2) the judgment regarding whether or not any particular case fits within the parameters of the problem area would best be made within a particular round, by the judge, rather than by those who assume they have mystically discovered the "spirit of the resolution."

"*How can . . .*" The first of the four phrases of the overall problem area places this year's debate problem area within the dimensions of a *policy* resolution. Traditional debate theorists categorize debate subjects as relating to problems of fact, value, and policy. These three categories are usually thought of as being cumulative; in other words, a value topic would incorporate both facts and values, and a policy topic would incorporate facts, values, and policy within its dimensions. When the problem area states that the advocates must attempt to determine "how can," one would suppose that affirmative teams would present a *mechanism* around which arguments would revolve. Further, use of the word "can" would seem to force affirmative teams to consider practical questions as well as theoretical issues in the development of the mechanism, or policy.

The debater who responds to the question will be expected to present a specific policy when on the affirmative. But will the negative team be expected to do the same? This writer would argue against such a requirement. If the answer to the overall problem area is "No, the affirmative policy is not the best way to improve health care of all United States citizens," then a judge should vote for the negative. No alternative is

necessary, because the judge is merely *rejecting* the affirmative policy. He need not compare two policies.[2]

"*The health care* . . . " One dictionary defines "health" as "physical and mental well-being; freedom from disease . . . physical condition, as, poor health."[3] The same source defines "care" as "mental pain; worry . . . watchfulness; heed . . . a liking or regard (for) . . . charge; protection . . . something to worry about, watch over, etc."[4] Thus, combining the two words from definitions provided in a dictionary would seem to provide a debater with one starting place. The well-being, freedom from disease, and physical condition of United States citizens would be watched over, protected by some agency.

But one approach, which might seem reasonable to most debaters, is not the only approach to the definition. *Black's Law Dictionary, Words and Phrases*, and other legal treatises, as well as court decisions, provide more technical definitions. Current legal statutes, both federal and state, provide viable definitions of the terms. Indeed, most private insurance policies provide an exact meaning for "health care" on the policy face. Debaters must consider alternative definitions, if for no other reason than to prepare for alternative approaches by their opponents.

The phrase "health care" implies a broad set of categories. One could start with the prenatal care of expectant mothers, continue through the life of the child, into adulthood, old age, and even after death when considering donation of usable organs.

The phrase might be interpreted to include natural or artificial forces which influence the health of United States citizens. The physical and mental well-being of our citizens is affected in adverse ways by conditions which exist in the United States. For example, pollution harms the well-being of citizens who live in our cities. Should such social problems be included within the parameters of the overall problem area? Similarly, crime causes injuries and deaths. Should watching over the health and well-being of our citizens include policies related to the reduction of violent crime? Clearly, the problem area implications of the phrase "health care" are broad. Debaters who are not eager to carry massive amounts of evidence might work harder on definitions.

"*Of United States citizens* . . . " Here, the straightforward meaning would appear best as one begins an analysis of the phrase. The Constitution provides a simple source for the phrase, and few would quibble about the meaning. People who reside within the territorial limits of the United States and possess citizenship would be the primary recipients of whatever policy the affirmative team ultimately supports. Inclusion of aliens, to avoid quibbling about recent court decisions and without claiming advantages therefrom, might seem appropriate.

Thoughtful persons, however, will have a little additional work. What about the citizen who resides outside of our boundaries? The absence of the word "all" makes the exclusion of these citizens possible. The problem area does not expressly indicate that every person who possesses citizen-

ship must be given service by the program. Rather, the phrase modifies "health care," indicating that the recipients of the care would be "United States citizens."

A second question, less pleasant to advocates of simplicity, also exists. If the question being discussed is how the health care of United States citizens can best be improved, some might answer that question by indicating actions of *other* countries which impinge upon the health care we receive. However tortured this definition might appear, such questions must be considered. What international agreements about drug enforcements are needed? How should food be distributed abroad? What immunization policies should be followed in the world? All these might be legitimate case areas if an affirmative employs this turn of the definition.

Most problem areas can be defined as consisting of fields of inquiry, both varied and complex in nature. Some aspects of the problem area are clearly centered in nature. Other aspects are peripheral in their import to the overall question being considered. In defining the problem area, this core/periphery concept would seem to be most useful. The problems mentioned in the above paragraph would seem on the edge of the problem area; those mentioned earlier would seem closer to the core of the problem area. Why does this writer make these distinctions? First, common sense led him to make the judgments; second, most discussions using the term "medical care" and "health care" center on the earlier meanigs; and third, the context of the phrase suggests the earlier meanings more than the later meanings.

When taken in context, the phrase "of United States citizens" modifies "health care" within the problem area. As a prepositional phrase, limited in power as part of the grammatical texture, it would most often be thought to mean the people who would be recipients of the health care introduced by affirmative teams in their debate cases.

"*Best be improved?*" This phrase may offer debaters some problems. The modifier "best" would seem to imply a more specific limitation than most debaters would like. Accustomed to "improved," "helped," "significantly bettered," debaters expect their cases to be measured against their opponents' cases rather than against some absolute term like "best." Yet that is the word chosen for the overall problem area. A similar difficulty emerges when the second portion of the phrase is considered, for "be improved" implies that the activity must already exist, eliminating consideration of health care activities which are, at this time, non-existent.

To expand upon the two problems mentioned above, suppose that the affirmative team has focused upon the immunization policies of the United States. Citing the failure of the swine flu immunization program in 1976 as the risk area, the affirmative proceeds to identify inherent flaws in the structure in the policy, implemented by all necessary means.

The first problem, relating to the choice of the word "best" in the overall problem area, is whether the policy suggested by the affirmative is the one which is the best *of all possible solutions*. A strict interpretation of the problem area would seem to mean that if the judge had a doubt that the

policy proposed by the affirmative were the *best* policy, he or she should vote for the negative, even if the negative policy was also less than the best.

The second problem, relating to the phrase "be improved," can also be seen within the above example. Had no national policy of immunization been attempted on swine flu, would the affirmative team be ignoring the problem area? For improvement might relate to existing *structures*, not existing *conditions*. In the former instance, a structure to provide flu shots would have to pre-exist the change. In the latter instance, a condition (such as the virus which caused swine flu) would have to pre-exist the change. Most theorists would probably prefer the latter meaning of the phrase.

Improvement entails identification of a condition which is disturbing to an observer. As most debaters now recognize, this improvement might be a consequence of either remediation of an "evil" or generation of a "good." Either represents improvement from the perspective of the debater. In either case, the debaters would seem to be bound to provide the judge with a policy which would make things better after its adoption. Whether that policy is the "best" of all possible worlds or merely the best of the worlds discussed in a particular debate round will be decided by the judge. To this writer, if a policy is better than what currently exists, and is worth the trouble to adopt, that policy would be sufficient to meet the meaning of the word "best" in the problem area.

Summary

The overall problem area provides debaters in 1977 with a broad field of inquiry. The policy question would seem to center on the ways the government could improve our health. The implications of the decision of the NUEA Advisory Council are potentially significant. If the judges respond to this advice, teams which ignore the territory established by the Overall Problem Area will lose rounds.

Proposition One: *Resolved: That the federal government should guarantee comprehensive medical care for all citizens in the United States.*

This proposition encompasses a complete range of medical care for citizens in the United States. Limits exist, and the following discussion should facilitate recognition of those limitations. Few debaters would want to propose "cradle to grave" medical care for all citizens. But does the resolution allow any alternative? That question, along with others, will be discussed below.

As with most propositions, three elements are present: (1) the agent of change, (2) the territory within which the supposed problem area exists, and (3) the individuals to be affected by the change. Additionally, this resolution would seem to require a policy as the focus of the central discussion, rather than the likelihood of that policy being adopted by some particular branch of government. The definitions incorporated into the discussion below should be augmented by careful research of each debater. The advice provided herein is intended as a starting point, not as an end in

itself. As with the overall problem area, the proposition will be discussed by considering the phrases included within the sentence.

"*The federal government...*" The agent of change within this proposition is identified as "the federal government." Since all three propositions begin with this term, it is discussed here, only. First, a general definition of the term will be provided, followed by three critical distinctions: (1) the proposition employs the word "the," not the word "a," (2) the proposition identifies the government in a generic rather than a general sense, and (3) the proposition isolates government, not private, actions as the agent of change.

In *general*, the phrase would seem to refer to the actions of the Congress, the President, and the Supreme Court of the United States. Any high school student should be aware that the action of that government frequently consists of grants-in-aid to states and municipalities as well as direct action by agents of the divisions of government. When the Corps of Engineers develops a waterway, when the Coast Guard provides aid to becalmed sailboats off the coast, or when the Internal Revenue Service answers a taxpayer's questions, each responds to an authorization by the federal government to meet the needs of United States citizens. Both financial assistance and direct action of federal employees represent federal actions.

But when does a grant-in-aid program stop being federal? Is the interstate highway system a federal or state project? Most citizens would agree that the highways are federal, but management is significantly local. No debater should ignore the implications of this question. The answer probably lies in the extent of the regulation imposed by the federal government as well as the amount of federal aid given.

The phrase uses the word "the," not the word "a." In the previous paragraphs few would doubt that the federal government being discussed was situated in Washington, D.C. This is the federal government meant by the term included in this year's propositions, but further clarification might be important to some debates this year.

Counterplans abounded in 1976-77 college debates. For many reasons, high school debate practices are influenced by college debate practices. Therefore, one might anticipate more counterplans on this year's topic than were proposed in previous years. These counterplans may differ only in the fact that adoption would occur on the state, not the federal, level. The claim of non-topicality is based upon the distinction between "the" and "a." When the several states act in concert, they create a federal union. But that union is not "the" federal government mentioned in the topic. Issued primarily as a justification argument, the counterplan provides another viable option for negative debaters.

The agent of change identified within all three propositions as "the federal government" is *generic*, not *general*, in meaning. The affirmative team will be expected to identify the particular agent which will be employed to implement the policy. Sometimes, that would be an existing government agency. Other times, a new agency would be required. In all

instances, the particular policy proposed by the affirmative would probably require congressional action. No one would expect an affirmative team to require action by the entire federal government. But to what point may an affirmative reduce the action agency? For example, would a change in an FDA regulation be a sufficient change according to this topic? One would suspect not. Would a funding program administered by the states, but with a few federal regulations, be enough? Here, this writer would suppose, substantial regulations, supervised by a federal agency, would be necessary to meet the meaning of "the federal government."

Finally, debaters need to consider the fact that "the federal government," not non-governmental actions, is the change agent. Although later comments may allow the affirmative teams to move toward government activities which are less than total in nature, the specific change should include governmental implementation.

"*Should guarantee . . .* " The second phrase of the proposition, "should guarantee," imposed two key obligations upon debaters. First, the affirmative team must establish the desirability of adoption, the "ought-ness" of the resolution. Second, the affirmative must prove the obligation of the government to "stand behind" the proposed action.

The term "ought-ness" implies a meaning similar to that of the word "should." Most theories of the art of debate imply that the activity revolves around the *desirability* of a proposed action, not the actualization of that action. The result is that teams debate propositions which include the word "should," not the word "would." The implication is that the teams will debate whether the policy should or should not be adopted, not whether the policy will actually become law as a consequence of balloting in the appropriate legislative body. Similarly excluded from consideration, given proper development of the affirmative policy, are such questions as constitutionality, court sanction, and enabling clauses which make the proposal practical. These excluded questions do not eliminate the central question imposed by "should." The policy must establish that the judge ought to support the policy, given the arguments in the round of debate.

Above, the notion that attitudes create behavior is implicit. Herein, this writer wishes to augment that assumption. Although the policy debate concerns itself with what should be done, the debate still must respond to the question of what *can* be done. The mood and power of the various governmental units, as well as powerful lobbies outside of government, must be considered.

The word "guarantee" provides the affirmative teams with some latitude. As noted earlier, the phrase "stand behind" might be an acceptable interpretation of "guarantee." When a manufacturer guarantees a product, the consumer expects replacement of defective parts. The manufacturer "stands behind" the product. However, other definitions may be acceptable for the term.

"Guarantee" may be interpreted to mean provision for that portion of medical care which individual citizens could not cover on their own. If

citizens paid a maximum of 10% of their annual income for medical care and the government paid the rest, the guarantee provided by the government would be in the form of a monetary subsidy. If citizens paid for all save certain types of illnesses, the guarantee would be based upon criteria other than dollars.

The federal guarantee might take the form of government standing behind private insurance company policies. Provision for a stipulated profit margin, irrespective of sudden increases in medical requirements for the insurees, might be the guarantee provided by the government. Debaters are warned, however, that the rigor of the regulation made by the government would determine the topicality of this approach.

Additional latitude exists for affirmative teams by reference to legal precedent. Guarantees are absolved when customers ignore stipulated conditions of the purchase. The government might well provide comprehensive medical care only when citizens maintain certain preventative care for themselves. Thus, conditions before the "warranty" could apply might allow affirmatives latitude.

"*Comprehensive medical care . . .*" "Comprehensive medical care" represents the condition anticipated following enactment of the proposition. Clarification of this phrase includes a focus upon each of the three words.

"Comprehensive" means "including much, inclusive,"[5] according to one dictionary. Few would expect the term to incorporate every aspect, however remote, of medical care. But how much is required of an affirmative team would seem to be important in defining the terms. Here, defining by residue may be helpful. Clearly, the topic does not say "non-comprehensive"; therefore, that which is not comprehensive would be inappropriate. Also, the topic does not ask the debaters to propose a policy which would correct merely one portion of the inadequacies in health care. Thus, a debater who treats merely one portion of the inadequacies must be prepared to prove that all other inadequacies are already guaranteed *or* that the inadequacy corrected *includes much* and is therefore comprehensive.

"Medical" denotes curative action, usually in conjunction with an illness and seeking of professional care. The many branches of medicine continuously augmented by expanding technological sophistication would seem to call for a broad system by which care could be obtained for illnesses. But where does the debater stop the policy? Does it include hospital care? Doctor treatment? Drugs for treatment of illness? Medicare and Medicaid both would seem to support the broader interpretation for medical care.

"Care" emphasizes the treatment aspect of medication. Knowing concern, informed action, and choice of action would all seem to be constituents of the word.

When these three words are rejoined, the meaning becomes relatively clear: an inclusive system of curative treatment seems most appropriate as the meaning of "comprehensive medical care."

"*For all citizens in the United States.*" The people who profit from the adoption of this proposition should ultimately be the citizens of this

country. The preposition "for" has many meanings. Most of these meanings suggest a direct relationship between the giver and the receiver—in this case, the federal government and the citizens. When the prepositional phrase modifies another phrase, the relationship intended is augmented by identification of the object; herein, the federal government is expected to provide comprehensive medical care for all citizens in the United States.

The phrase does not require that all citizens in the United States take advantage of the opportunity for comprehensive medical care. That the care is available for the citizens would seem to be sufficient. For example, tax exemptions are equally available for all eligible citizens, but all citizens do not employ all tax exemptions.

Two groups would seem to be excluded by this phrase, at least in the sense of representing the advantage to be obtained: non-citizens who reside within the United States and citizens who reside outside the United States. Such exclusions appear reasonable and straightforward. (As noted earlier, however, recent court decisions may require the inclusion of aliens who reside within the United States.)

Summary

The agent of change within this proposition is the federal government. An affirmative team may select the best mechanism within that framework and may even extend the framework to incorporate non-federal actions, if the core of the system is federal in nature.

The responsibility of the agent of change is to stand behind the treatment of citizens' medical problems. In one sense, the topic presses the notion that health care is a right of all citizens which ought to be secured.

The desired action of the proposition is comprehensive, substantially complete medical care. Whether this comprehensivity is merely augmented by the direct medical program of the federal government or totally implemented by the federal government remains the argumentative task of the debaters.

Those who are the beneficiaries of the change are the people who reside in the United States and are citizens. The benefits these people will receive are contingent upon the cases developed by the affirmative teams.

Proposition Two: *Resolved: That the federal government should establish a national program of malpractice insurance for all health care professionals.*

Proposition two focuses upon a much narrower question than does either of the other alternatives within the overall problem area. Here, debaters are expected to argue about the relative merits of federal intervention in the process by which health care professionals protect themselves from legal suits. As with any proposition, rationales for such intervention may vary substantially. But the thrust of the proposition clearly leads to discussion of the allegations of citizens about medical practices which may reach civil courts.

As noted earlier, the phrase "the federal government" will not be included in this section. Students who have skipped the definitions of the prior proposition should return there for definition of this phrase. By the same token, material related to the word "should" is also omitted here.

"*Establish a national program . . .*" The proposition asks affirmative teams to *establish*, not to augment. The choice of the word "establish" denies the affirmative team certain options. If a national program by the federal government already exists, then the affirmative would seem required to establish a different program. Because establishment entails some degree of continuity, setting up the machinery for a national program would not seem sufficient to meet the obligations of this proposition. Further, a simple takeover of an already existing national program by the federal government would also seem inappropriate, given the central meaning of the word "establish."

The phrase "a national program" would also limit the affirmative team. Herein, the obligation of the affirmative to support a program is evident. But the nature of the program is further delineated—it is one which is national in scope.

Some room for variation does remain for affirmative teams. A national program need not require membership by all health care professionals. The program must, however, be available for those health care professionals who desire it. Further, "establishing" a national program does not entail permanence to the same degree as another verb choice might have implied.

In brief, the phrase constrains, but does not specifically delimit, the nature of the affirmative policy. The nature of that policy is clarified by the next phrase of the proposition.

"*Of malpractice insurance . . .*" Doctors currently pay very high insurance premiums as protection from civil suits based upon negligent medical practice. Insurance companies have chosen to increase their rates as a consequence of their legal rights within the several states and their judgment of the financial risks in providing the insurance. The subject of the insurance, malpractice, is defined by law.

A student debating this proposition will find a wealth of conflicting statutes existing in the several states. But at base, an insurance policy is a "contract whereby a person or company guarantees payment for a specified loss."[6] Malpractice insurance would be a contract whereby health care professionals would be guaranteed payment of damage suits instituted and won by their clients.

"*For all health care professionals.*" The beneficiaries of the national program envisioned by this proposition would be those covered by the insurance policies. Health care professionals have generally been identified by their certification status in the several states. Doctors, surgeons, nurses, and radiologists would be incorporated into the broad term—so might dieticians, chiropractors, and individuals involved in rehabilitation. Whether the individuals who remain outside of the federal

definition of "health care professionals" provided by the affirmative team in a round of debate *should* have been included will have to be addressed by the debaters in that round.

One approach which might aid debaters is to learn what malpractice suits have been won in court. If a nurse has lost a malpractice suit, then that person might need the protection of the federal government. By the same token, if someone providing rehabilitative care has been sued successfully, then he or she might need the protective cover of a national program of malpractice insurance.

Summary

Proposition two anticipates clash between teams regarding the desirability of a national malpractice insurance policy established by the federal government. That policy should be for all health professionals.

Proposition Three: *Resolved: That the federal government should establish a comprehensive program to regulate the health care system in the United States.*

The third and broadest of the three propositions is imprecise. The ambiguity created by the phrase "to regulate" is covered below. Omitted, as in proposition two, will be terms treated within discussion of the first proposition: "the federal government," "should," and "comprehensive." Additionally, the terms within the phrase "establish a comprehensive program" are defined within proposition two discussions and are omitted below.

"*To regulate* . . . " Returning to the familiar dictionary approach, the word "regulate" is defined as "to control or direct according to a rule, principle, . . . to adjust to a standard, . . . to adjust so as to make work accurately."[7] The options available to affirmative teams would appear to include almost anything from total *rule* to *adjustment* by specific modifications.

The word "regulate" as it applies to governmental activity generally means establishment of a regulatory agency. The powers of the various federal agencies vary with the task assigned. The Food and Drug Administration can totally ban the sale of a dangerous drug. The Federal Communication Commission determines, in quasi-judicial hearings, whether radio or television station licenses are renewed. The Bicentennial Commission promoted our two-hundredth birthday. Yet each agency "regulated" activities within its perview.

We "regulate" a clock by adjusting parts of its system. An affirmative team might regulate the health care system by adjusting some of its parts. Clearly, the comprehensiveness of the program established to regulate the health care system should be determined by the breadth of the program, but an alternative standard of definition might be the extent of the *effect* upon the system. Most theorists of debate expect topicality to be decided by the nature of the policy, alone. But some would admit the effect of the policy would be an appropriate standard.

"*The health care system in the United States.*" The final terms treated in this first section on the 1977 topic are probably the most complex. For purposes of clarification, the word "system" is treated first, followed by a discussion of "health care."

Men like Jean Piaget of the world of child psychology have been joined by modern mathematicians in using the word "system" to describe many different phenomena. Generally speaking, systems can be categorized as open or closed. In political science, few systems are closed.

For example, Jimmy Carter's election can be considered from a systems perspective. The primaries, conventions, general election, and balloting of the electoral college can be considered primary elements of the system of electing the President of the United States. But that system is not closed. Instead, many factors affect the election of a president in our country. The 1976 televised debates influenced the election. The 1972 election was affected, albeit incompletely, by Watergate. In 1968, a continuing war in Vietnam influenced the presidential election. Clearly, certain factors remained constant in all three elections, while other factors changed.

Those factors which remain constant would certainly be part of the system, and those factors which do not remain constant might be thought of as not being part of the system unless one could prove the likelihood of their permanence. The system can be identified by *consistency*.

A second element of a system is the *necessity* of the particular aspect to the continuity of the system. Could a clock continue without a mainspring? If not, then the mainspring is necessary to the system we call a clock. Could the health care system of the United States exist without practitioners? If not, then they are essential elements in the system.

The third element usually associated with defining a system is the *self-regulation* entailed by the system. Not to be confused with the prior discussion of regulation, this term relates to the continued survival of the activity being described. The elements of a system work to keep that system operating. Pun notwithstanding, the health care system of the United States has persisted for many years. There is apparently some systemic quality which keeps it operating.

In summary, a "system" can be defined as open or closed. When advocates focus upon something as extensive as the health care system in the United States, consideration of that system as *open* yields absolutely no limitations upon the topic. Consideration of that system as *closed* does yield limitations: (1) continuity limitations, (2) necessity limitations, and (3) self-regulatory limitations. Affirmative teams should focus upon those elements which contribute to the closed system operating in the United States which provides health care to people.

"Health care" as distinguished from "medical care" is much broader in its implications. Preventative actions would be included. So would activities which enhanced good health. The range of human behavior relating to health care is exceedingly broad. Medical care, from this perspective, would seem to be a sub-set of the broader term, "health care." A debate team which excluded the broader dimensions of health by

narrowing the focus to medical activities should anticipate negative topicality attacks.

Summary

Debating the third proposition entails a grasp of the system by which health care is supported within the United States. The debaters on the affirmative side are expected to establish a program which includes much of that system being regulated by the federal government. The type of regulation, extent of the system affected directly by the regulation, and the incumbent advantage of that regulation are all questions to be resolved by the specific round of debate.

Present Structures of Health Care

The health care "system" of the United States can be examined from a great many different perspectives. Getting a handle on the various structures which are part of the health care system is critical to debaters in 1977. This section is designed to provide some of those handles. As with any preliminary study of a broad subject, these materials merely scratch the surface, but they will hopefully suggest directions for additional research.

The five topics discussed below are (1) health care costs, (2) government and health care, (3) ill health in the United States, (4) the health professionals, and (5) facilities and treatment. Clearly, when one discusses health care costs, items relevant to ill health must be included. Similarly, to discuss facilities and treatment entails reference to the health professionals of our country. Thus, no single topic of this section will really be independent of any other topic. Charts from one section will incorporate data important to other sections.

In 1977, high school debaters will attempt to answer many questions about the system of health care in the United States. For example, people in the United States spent 8.6% of the gross national product on health care in 1976. "The average American works one month of the year to pay the bills for health."[8] For their money, do Americans receive enough in the way of health care?

Americans die, but few die without the attention of better technicians, facilities, and medications than have been available throughout our history. Could these technological advances be improved? Should Americans be expected to live better and longer? And what mechanisms should our agencies of government be expected to employ to obtain a more healthy life for Americans?

Our government continues to be substantially involved in health care. In 1976, 42.2% of total expenditures on health came from public sources. But does the government employ the best structure for providing that portion of expenditures? Is the amount provided by the government well-spent?

Health Care Costs

Health care costs have soared in the United States. Between 1929 and 1971 real income (spendable income) per capita rose 5.3 times. The cost of living rose only one and one-third times. Within the health care area, per capita expenditures on all health sources rose *twelve* times and hospital care increased *twenty-five* times.[9] In 1929, Americans spent $29.16 on health. In 1976, the figure rose to $637.97.

Much of the information about this year's debate proposition will come from close study of charts. Note, for example, the *trends* within Table 1. The percent of our gross national product expended upon health care has steadily increased. Reflected in both private and public figures, Americans spend more now than in the past on health. But, when the percentages are examined, they show that the trend of public expenditure is increasing while private expenditure is declining.

Data from the *Social Security Bulletin*, *Statistical Abstract*, and a number of documents from the Department of Health, Education, and Welfare will be invaluable to debaters. As can be seen in Table 1, for example, price controls influenced health care costs. The prices remained relatively stable in 1973, then leapt upward after controls were removed.

Further data regarding the increased costs of health care can be found in Table 2. The increases have not been across the board. Rather, certain sectors of medical costs have increased substantially more than other sectors.

Clearly, the careful researcher must learn to understand indices to make appropriate comparisons of the data on this year's topic. For example, Table 2 contains significant information: among other things, the substantial jump in costs of private room charges may well indicate a way by which individual patients might reduce their hospital care costs, for private rooms are a luxury, not a necessity, for many patients. Further, the careful researcher will probe into the "hospital service charge" item, attempting to discover whether additional modification of hospital costs might occur without damage to patient recovery.

Hospital care costs increased more than any other aspect of health care in 1975.[12] The increases were so substantial that Deputy Assistant Secretary Stuart Altman commented, "Costs are now 16% over a year ago and each month they are going higher. There is the potential to blow our system right out of the water."[13] Physicians' services accounted for another 12.9% of the expenditures on health care in 1975.[14] A further view of expenditures by category appears in Table 5.

As noted earlier, these expenditures have been considered a public task since 1930. Combining government and insurance payments accounts for 65% of all medical payments, 90% of all hospital costs, and 61% of all doctors' fees.[15] And government spending increased twice as rapidly as private spending.[16] The questions which will require careful analysis of specific issues relate to *why* the prices are increasing. Inefficient government? Augmented technological procedures? Greed? All these, and many more, may serve as causal links to the increases.

Table 3 provides a graphic view of the upward spiral. The sharp increases in 1965 and 1968 both represent puzzles the 1977 debater must try to solve. One clue: increased services based upon demand often mean increased prices.

Table 4, a companion graph included for comparison values, indicates the increases in hospital costs compared to workers' earnings.

A final view of national health expenditures is necessary. Table 5,

Table 1. Aggregate and Per Capita National Health Expenditures, by Source of Funds, and Percent of Gross National Product, Selected Fiscal Years, 1929-1976.[10]

Fiscal year	Gross national product (in billions)	Health expenditures								
		Total			Private			Public		
		Amount (in millions)	Per capita	Percent of GNP	Amount (in millions)	Per capita	Percent of total expenditures	Amount (in millions)	Per capita	Percent of total expenditures
1929.....	$101.3	$3,589	$29.16	3.5	$3,112	$25.28	86.7	$477	$3.88	13.3
1935.....	68.9	2,846	22.04	4.1	2,303	17.84	80.9	543	4.21	19.1
1940.....	95.4	3,883	28.98	4.1	3,101	23.14	79.9	782	5.84	20.1
1950.....	264.8	12,027	78.35	4.5	8,962	58.38	74.5	3,065	19.97	25.5
1955.....	381.0	17,330	103.76	4.5	12,909	77.29	74.5	4,421	26.47	25.5
1960.....	498.3	25,856	141.63	5.2	19,461	106.60	75.3	6,395	35.03	24.7
1965.....	658.0	38,892	197.75	5.9	29,357	149.27	75.5	9,535	48.48	24.5
1966.....	722.4	42,109	211.56	5.8	31,279	157.15	74.3	10,830	54.41	25.7
1967.....	773.5	47,879	237.93	6.2	32,026	159.15	66.9	15,853	78.78	33.1
1968.....	830.2	53,765	264.37	6.5	33,725	165.83	62.7	20,040	98.54	37.3
1969.....	904.2	60,617	295.20	6.7	37,680	183.50	62.2	22,937	111.70	37.8
1970.....	960.2	69,201	333.57	7.2	43,810	211.18	63.3	25,391	122.39	36.7
1971.....	1,019.8	77,162	368.25	7.6	48,387	230.92	62.7	28,775	137.32	37.3
1972.....	1,111.8	86,687	409.71	7.8	53,214	251.50	61.4	33,473	158.20	38.6
1973.....	1,238.6	95,383	447.31	7.7	58,715	275.35	61.6	36,668	171.96	38.4
1974 1/.....	1,361.2	106,321	495.01	7.8	64,809	301.74	61.0	41,512	193.27	39.0
1975 1/.....	1,452.3	122,231	564.35	8.4	71,361	329.48	58.4	50,870	234.87	41.6
1976 2/.....	1,611.8	139,312	637.97	8.6	80,492	368.61	57.8	58,820	269.36	42.2

1/ Revised.
2/ Preliminary.

Table 2. Percentage of Increase in Health Costs, 1965-1975.[11]

	PERCENTAGE INCREASE					
Fiscal Year	CPI All Items	Medical Care Total	Hospital Service Charges*	Hospital Private Room Charges	Physicians' Fees	Dentists' Fees
1965	1.3	2.1	-	5.3	3.1	2.9
1966	2.2	2.9	-	6.1	3.9	2.9
1967	3.0	6.5	-	17.3	7.4	4.5
1968	3.3	6.4	0	15.9	6.1	5.2
1969	4.8	6.5	-	13.5	6.1	5.8
1970	5.9	6.4	-	12.8	7.2	6.8
1971	5.2	6.9	-	13.3	7.5	6.0
1972	3.6	4.7	-	9.4	5.2	5.7
1973	4.0	3.1	3.2	5.0	2.6	3.1
1974	9.0	5.7	7.9	6.0	5.0	4.4
1975	11.0	12.5	15.4	16.4	12.8	10.8

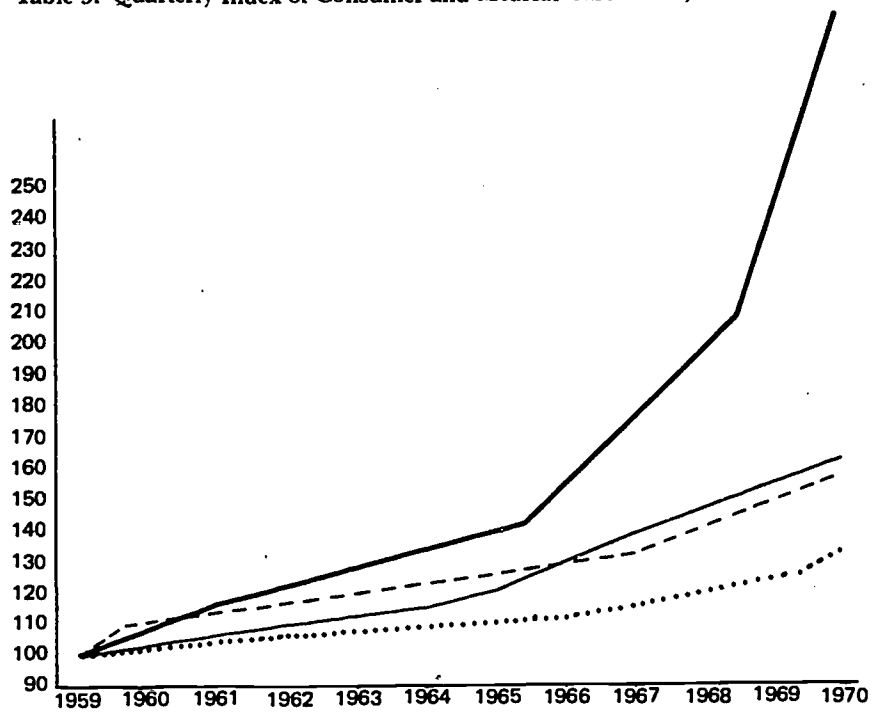
*Index Information not available until 1973

prepared by the Division of Health Insurance Studies, provides a great deal of data for analysis. The Social Security reports include the kind of information that provides points of departure for arguments about our health care system. Clearly, important details emerge as a result of careful analysis of tables such as this one.

Note particularly the differences between funds expended by private and public sources on the various items included in the table. For example, the 1976 preliminary estimates indicate little public involvement with the payments for eyeglasses and appliances. Yet these items are important concerns for the elderly. Additionally, note the minimal public funds expended in 1976 on drugs and drug sundries. Given the breadth of the drug industry, discussed elsewhere in this report, debaters might wonder that such a small portion of drug expenses are paid by the public sources.

Use of information such as that found in Table 5 is augmented by specific data from other sources. Consider the implications of little money applied from federal, state, or local public sources for eyeglasses, when combined with the following statement: "The average health care bill for a person 65 or older was $1,360 in fiscal 1975, almost six and one half times the average health care expenses of persons under age 19 and three times that of people ages 19 to 64."[20] The elderly need glasses, spend more on health care than others, and yet receive no aid to offset the costs of glasses. While the situation is oversimplified here, the implications for potential argumentative use of data should be clear.

Table 3. Quarterly Index of Consumer and Medical Care Prices, 1959-70.[17]

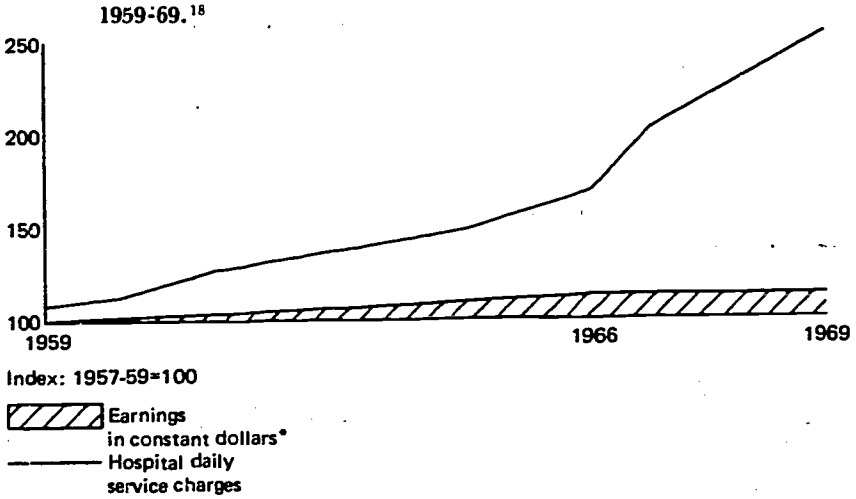


Government and Health Care

Probing the health care system of the United States cannot stop with general cost calculations. A second category which must be considered is the activities of the government regarding health care. Herein, a substantial amount of attention will be given to federal activities. The debater is cautioned, however, that there are many activities on the part of other levels of government which affect health care. States, counties, and municipalities play important roles in the availability of health care to our citizens.

"Government spending for health care rose to $41 billion in 1975, an increase of 22% over fiscal year 1974. The largest increase was for the aged (27%) reflecting a rise of 31% in Medicaid spending and an increase of 29% in Medicare expenditures for this group. Medicare payment accounted for 72% of hospital expenditures for the aged and 54% of doctor bills."[21] The

Table 4. Comparison of Increases in Hospital Costs and Workers' Earnings, 1959-69.[18]



Sources: Social Security Administration and Bureau of Labor Statistics

*Average weekly take-home pay, after federal taxes, of nonsupervisory worker in private employment.

government accepts fiscal responsibility for much of the current health care in the United States.

In studying the role of government in health care, debaters will encounter many problems that they may want to probe. For example, one reason for the increased cost of governmental assistance can be found in the current federal formula for aid: "Social Security Commissioner James B. Cardwell said the increase was necessary to keep pace with hospital costs that have been rising twice as fast as the cost of living. His administration is required to follow a federal formula each year in determining the future cost of the Medicare program to beneficiaries."[22] Thoughtful debaters will become knowledgeable about as many of these problems as possible.

Following are brief sketches of the major governmental programs of health care today. Each is a part of the system of health care in our country. Each deserves substantially greater treatment. But each is limited by space within this preliminary analysis.

Medicaid

"The expense of medical care had reached a critical stage with the Depression of 1929-32 when individuals found it increasingly difficult to pay their medical bills."[23] The Social Security Act of 1935 helped to "pay the costs of the indigent sick, the disabled, the elderly and such special groups as veterans, migrant farmers and American Indians."[24]

By 1950 health care expenditures had risen to a new critical level, and numerous Americans sought assistance from the federal government. "In

Table 5. National Health Expenditures, by Type of Expenditure and Source of Funds, Fiscal Years 1974-1976.[19]

(In millions)

Type of expenditure	Total	Source of funds					
		Private			Public		
		Total	Consumers	Other	Total	Federal	State and local
	1976 1/						
Total	$139,312	$80,492	$75,622	$4,870	$58,820	$39,863	$18,957
Health services and supplies	131,022	77,722	75,622	2,100	53,300	36,247	17,053
Hospital care	55,400	25,004	24,352	652	30,396	21,394	9,002
Physicians' services	26,350	19,718	19,700	18	6,632	4,884	1,748
Dentists' services	8,600	8,131	8,131	---	469	288	181
Other professional services	2,400	1,607	1,559	46	793	540	254
Drugs and drug sundries 2/	11,168	10,144	10,144	---	1,023	550	474
Eyeglasses and appliances	1,980	1,866	1,866	---	114	61	53
Nursing-home care	10,600	4,744	4,706	38	5,856	3,417	2,439
Expenses for prepayment and administration	7,335	5,709	5,165	544	1,627	1,322	306
Government public health activities	3,255	---	---	---	3,255	1,243	2,012
Other health services	3,933	800	---	800	3,133	2,548	585
Research and medical-facilities construction	8,290	2,770	---	2,770	5,520	3,616	1,904
Research 2/	3,327	258	---	258	3,069	2,818	251
Construction	4,963	2,512	---	2,512	2,451	798	1,653
Publicly owned facilities	1,673	---	---	---	1,673	37	1,636
Privately owned facilities	3,290	2,512	---	2,512	778	761	17

1950, the national health expenditures totalled $12 billion, 4.6% of our gross national product, or $78 per capita."[25] The government responded by expanding the Social Security Act by amendment in 1950. The amendment "provided for the dependents of the uniformed services; health insurance for civil servants; and expanded health programs for the Indians and Alaskan natives."[26] Like the prior act, the amended one provided only temporary relief.

By 1965, health expenditures "approached $39 billion, 5.9 percent of the Gross National Product, or $198 per capita."[27] Title XVIII of the Social Security Act provided for a national medical and hospital insurance program. The Title XVIII program "established the State-option medical assistance vendor payment program popularly known as Medicaid."[28]

Medicaid is "a public assistance program which uses state and local tax money as well as federal funds to provide medical care for the poor. Each state is required to provide health care benefits to those persons who qualify for public welfare. If they desire, states may also extend coverage to the 'medically indigent'—those persons who do not qualify for public assistance but whose incomes are too low to cover medical expenses. The federal share of state Medicaid funds ranges from 50 to 78 percent depending upon the state's per capita income."[29]

Medicaid recipients must meet certain *categorical relatedness* requirements. "To be categorically related, a recipient must be aged, blind, disabled, or a member of a family with dependent children."[30] These requirements are waived for needy individuals under the age of twenty-one.[31]

The program continues to expand. In July 1974, an estimated 7.8 million persons had medical vendor payments totalling 884 million dollars made in their behalf. By July 1975, 8.5 million recipients had medical vendor payments totalling $1.089 billion made in their behalf. In January 1976, approximately 9.07 million recipients had vendor payments totalling $1.231 billion made in their behalf.[32]

Questions relating to fraud, to abuse, and to those who still do not obtain care despite the breadth of the categorical program must be considered by debaters.

Medicare

Medicare is a federal health care insurance program for people sixty-five and older and for some disabled people. The program has been plagued with cost overruns, as noted by Stuart Auerbach: "Even in the first year of the program the $3.4 billion in outlays was $400 million more than anticipated."[33] The bill, signed into law by Lyndon B. Johnson in 1965, does not provide for costs of drugs, eyeglasses, dentures, and hearing aids, according to Don Morphew of the Social Security Administration.[34] Another problem area is nursing homes, many of which are inadequate, and some even inhumane.[35]

But Medicare does assist in payment of health costs. "As a general rule, after you have $60 in reasonable charges for covered medical expenses in

each calendar year your medical insurance will pay 80 percent of the reasonable charges for any additional covered services you receive the rest of the year."[36]

How do the elderly pay for the rest of their medical expenses? One detractor of the present system noted that the usual method for younger citizens, private insurance, is not available to the elderly. "Private health insurance covering long-term care is difficult to obtain even for the young and healthy. For the high-risk older population, it is virtually non-existent."[37]

Hill-Burton Act of 1946

The Hill-Burton Act, passed by Congress in 1946, authorized grants to states for surveying needs and developing state plans for construction and equipping of needed public and voluntary non-profit general, mental, tuberculosis, and chronic-diseases hospitals and public health centers.

Each year since 1947 Congress has appropriated substantial federal funds for this purpose, with the money being matched by from one-third to two-thirds state or local funds. From 1947 until 1972, $3.8 billion were awarded to some 10,939 projects totalling $13.2 billion investments.[38] A view of the program from 1947 until mid-1971 is available in Table 6.

One of the most pressing problems of the health delivery system of the United States prior to the adoption of the Hill-Burton Act was the absence of proper facilities in rural areas. The intent of the act was clearly to make this situation change. As can be observed in Table 7, community size significantly influenced the grants of this program.

Another important variable in the grants is the wealth of the individual state. Further, county income is influential in grants. Low median family income within a given county is illustrated in Table 8.

The major provisions of the Hill-Burton Act are as follows: (1) an inventory of existing hospitals and a survey of the need to develop new programs for construction are required; (2) funds are to be allocated on the basis of population and per capita income; (3) grants are provided for construction projects; (4) income is provided to states only when the states have designated a state agency, established a state advisory council, and submitted a state plan; (5) the Surgeon General is designated to develop regulations prescribing the number of beds, the number of public health centers, the manner in which priorities will be determined for rural communities, and standards for construction of and equipment for hospitals; and (6) grants are made available only to states which enact or have enacted legislation for providing minimum standards of maintenance and operation of hospitals receiving federal aid under the program.

Five amendments to the act have been passed; each provided additional input to the health care system of the United States; all relate to hospital facilities, or their replacements:

In 1949 the Hospital Survey and Construction Amendments were adopted to extend the program funding and authorize research and demonstration programs.

Table 6. Hill-Burton Projects Approved, by Type, 1 July 1947-30 June 1971.[39]

Type of Facility	Total Projects		Inpatient Care Beds Provided		Outpatient and Other Health-Care Facility Projects		Cost		
								Hill-Burton funds	
	Number	Percent	Number	Percent	Number	Percent	Total ($ thousands)	Amount ($ thousands)	Percent
Total	10,748	100.0	470,329	100.0	3,083	100.0	12,765,900	3,717,979	100.0
Short-term hospitals	5,787	53.8	344,453	73.2	131 [a]	4.2	9,322,392	2,635,494	70.9
Long-term care	1,733	16.1	97,358 [b]	20.7	—	—	1,613,808	523,111	14.1
Units in hospitals	1,097	10.2	51,983	11.1	—	—	904,409	312,499	8.4
Nursing homes	528	4.9	37,884	8.1	—	—	571,057	171,648	4.6
Chronic disease hospitals	108	1.0	7,491	1.6	—	—	138,342	38,964	1.0
Mental hospitals	198	1.8	21,034	4.5	—	—	246,734	78,493	2.1
Tuberculosis hospitals	78	.7	7,484	1.6	—	—	75,228	27,661	.7
Outpatient facilities [c]	1,078	10.0	—	—	1,078	35.0	708,952	204,083	5.6
Rehabilitation facilities	552	5.1	—	—	552	17.9	440,019	135,010	3.6
Public health centers	1,281	11.9	—	—	1,281	41.6	289,049	99,689	2.7
State health laboratories	41	.4	—	—	41	1.3	69,718	14,438	.4

[a] Public health centers built in combination with short-term hospitals and not reported as separate projects.

[b] Excludes 7,209 long-term care beds built in conjunction with short-term and other hospital projects, for which funds cannot be separated from total project costs. These beds are reported in the following categories of facilities: general hospitals—7,113 beds, mental hospitals—60 beds, tuberculosis hospitals—36 beds.

[c] Previously designated "diagnostic or treatment centers."

Source: U.S. Department of Health, Education and Welfare, *Hill-Burton Project Register* (Washington, D. C.: U.S. Government Printing Office, 1972), p. 2.

Table 7. Distribution of Hill-Burton Projects and of Population, by Community Size, 1948-71.[40]

(In percents)

1960 Community Size	Sample of Short-Term Hospitals Supported, 1948–71			Total Projects, 1968–70			1960 Population [a]
	Total number of projects	Costs met by Hill-Burton funds	Hill-Burton funds	Total number of projects	Hill-Burton funds	Inpatient beds	
Less than 2,500 and rural	14.9	37.4	7.0	17.1	9.7	9.6	36.0
2,500–4,999	14.1	30.0	9.3	13.2	9.5	9.6	4.2
5,000–9,999	14.4	32.6	12.6	15.1	14.6	14.7	5.5
10,000–24,999	19.8	29.3	22.0	15.2	17.3	17.6	9.8
25,000–49,999	11.6	25.9	16.3	9.9	12.2	12.2	8.3
50,000–99,999	6.9	33.3	9.0	7.3	8.9	9.0	7.7
100,000–249,999	7.4	23.7	10.6	8.0	9.7	9.8	6.5
250,000 and more	10.8	21.1	13.3	14.2	18.1	17.5	22.0
Total	100.0	—	100.0	100.0	100.0	100.0	100.0

[a] 5.5 percent of the population lived in unincorporated parts of urbanized areas. However, 30.1 percent of the population lived in towns smaller than 2,500, did not live in urban fringes, and did not live in unincorporated places with a population density of 1,500 per square mile or more, that is, in rural areas.

Note: Here and in subsequent tables, details may not add to totals due to rounding.

Source: Short-term hospitals data from HEW, *Hill-Burton Project Register;* inferences drawn from a one-fifth sample of hospitals ever supported. Total projects data from HEW, *Hill-Burton Progress Report,* 1 July 1947–30 June 1970, p. 23. Population data from U.S. Bureau of the Census, *Statistical Abstract of the United States, 1972* (Washington, D. C.: U.S. Government Printing Office, 1971), p. 17.

Table 8. Percentage Distribution of Funds to Short-Term Hospitals, by County Family Income, 1948-71.[41]

1960 Median Family Income of County in Which Hospital is Located	Total Projects	Hill-Burton Grant Funds	Construction Costs Financed by Hill-Burton
Less than $3,000	13.0	8.2	45.5
$4,000–$4,999	15.0	11.5	41.7
5,000– 5,999	23.0	23.6	33.7
6,000– 6,999	29.8	30.3	26.7
7,000– 7,999	13.8	17.4	21.5
8,000– 8,999	5.1	8.3	17.7
9,000– 9,999	.4	5.7	20.0
10,000 and over	0.0	0.0	0.0
Total	100.0	100.0	—

Source: Based on a one-fifth sample of short-term hospitals listed in HEW, *Hill-Burton Project Register.*

The Medical Survey and Construction Act of 1954 granted funds for construction of diagnostic and treatment centers, chronic disease hospitals, rehabilitation facilities, and nursing homes.

In 1961, the Community Health Services and Facilities Act allocated funds for nursing home construction and provided for improved services for the aged and the chronically ill.

The Hospital and Medical Facilities Amendments of 1964 extended the program with grants specifically for modernization of hospitals, with priority given to urban areas.

The Medical Facilities Construction and Modernization Amendments of 1970 provided a new program of project grants for emergency rooms, communication networks, and transportation systems.[42]

Veterans Affairs

In 1930, the Congress created the Veterans Administration by consolidating the Veterans Bureau with the National Home for Disabled Volunteer Soldiers and the Bureau of Pensions. The Veterans Administration now provides mental hospitals, out-patient care, and hospitalization to all veterans who qualify for these services. Currently, the health care portion of the Veterans Administration provides skilled nursing care and related medical care in Veterans Administration or private nursing homes for convalescents or persons who are not acutely ill and not in need of hospital care. Medical and dental care constitute the second major service of the Veterans Administration. They are available on a priority basis, first to service-disabled veterans, then to pensioners, veterans over 65, and

indigent veterans. They account for roughly 20% of the agency's budget. In 1974, this translated to nearly $3 billion, up from $1.9 billion in 1971.

The Veterans Administration runs the largest hospital system in the nation.[43] Currently there are 171 hospitals, 213 clinics, and 84 nursing homes in 176 towns and cities operated by the Veterans Administration in the United States.[44] The Veterans Administration offers the same benefits as a private hospital or physician would offer, except there is no service fee or minimum charge.

Mental Health

"The necessity for estimating psychiatric bed needs has, if anything, increased in recent years. A search of current journal literature by the National Library of Medicine in January 1974 revealed only eighteen articles during the decade between 1964 and 1973 which deal numerically with psychiatric bed needs."[45] This statement, from the National Institute of Mental Health in 1975, indicates one difficulty in reporting on the status of mental health in the United States.

The National Institutes of Health (NIH), established by the federal government, consists of nine specific categories. The National Institute of Mental Health (NIMH) is one of these institutes. Bertram S. Brown, Director of the American Hospital Association Advisory Panel on Financing Mental Health Care, noted: "The future scope and extent of mental health care available to the American people will depend on policy decisions at all levels of government and on the kind and degree of participation by people and private resource sectors in the financing of mental health services."[46]

The *Statistical Abstract* does provide some statistical data on mental patient care in the United States. As can be observed in Table 9, in 1973 1.6 million patients received in-patient services in mental facilities. In the same year, three million patients received out-patient services. Over 2.2% of our population received in- or out-patient services in mental health facilities of the United States in 1973. However, this calculation is not trustworthy, for multiple entry by a single patient might reduce the incidence of treatment. Further study of the data is necessary.

Public institutions for the mentally retarded also fall within this general category. In 1950, 96 such institutions existed in the country, and by 1971, there were 190. At the beginning of 1971, 185,855 resident patients were maintained in these treatment centers (see Table 10).

A final view of mental care in the United States is available in Table 11. In this table, numbers of patients in mental care facilities for the years 1971, 1973, and 1974 are given for each state.

Medical Research

During the past seventeen years, the scope of biomedical research in this country has expanded tremendously. Medical research today requires specially trained people in specially designated environments. The national pool of qualified investigators and of institutions equipped to undertake significant research programs is strictly limited. The basic unit

Table 9. Patient Care Episodes in Mental Health Facilities, by Type of Treatment Facility: 1955 to 1973.[47]

[Patient care episodes are defined as the number of residents in inpatient facilities at the beginning of the year (or the number of persons on the rolls of noninpatient facilities) plus the total additions to these facilities during the year]

ITEM AND YEAR	All facilities	INPATIENT SERVICES						OUTPATIENT SERVICES		
		Total	Mental		General [2]	VA [3]	Community mental health centers	Total	Community mental health centers	Other
			State and county	Private[1]						
Patients (1,000):										
1955	1,675	1,296	819	123	266	88	(NA)	379	(NA)	379
1965	2,637	1,566	805	125	519	116	(NA)	1,071	(NA)	1,071
1967	3,140	1,659	801	124	579	128	27	1,480	97	1,383
1969	3,573	1,678	767	124	535	187	65	1,894	291	1,603
1971	4,038	1,721	745	127	543	177	130	2,317	623	1,694
1973	4,749	1,680	652	152	475	208	192	3,070	983	2,087
Percent distribution:										
1955	100.0	77.4	48.9	7.3	15.9	5.3	(NA)	22.6	(NA)	22.6
1965	100.0	59.4	30.5	4.8	19.7	4.4	(NA)	40.6	(NA)	40.6
1967	100.0	52.9	25.5	4.0	18.4	4.1	0.9	47.1	3.1	44.0
1969	100.0	47.0	21.5	3.5	15.0	5.2	1.8	53.0	8.1	44.9
1971	100.0	42.6	18.5	3.1	13.4	4.4	3.2	57.4	15.4	42.0
1973	100.0	35.4	13.7	3.2	10.0	4.4	4.1	64.6	20.7	43.9
Rate per 100,000 population:										
1955	1,032	799	505	76	164	54	(NA)	234	(NA)	234
1965	1,374	816	420	65	271	60	(NA)	558	(NA)	558
1967	1,604	848	410	64	296	66	14	756	48	707
1969	1,798	850	384	62	268	94	42	948	145	803
1971	1,982	847	365	66	266	87	64	1,134	305	829
1973	2,282	807	313	73	229	100	92	1,475	472	1,003

NA Not available. [1] Includes episodes of care in residential treatment centers for children. [2] With psychiatric service.
[3] Veterans administration; includes neuropsychiatric and general medical and surgical hospitals.

Source: U.S. National Institute of Mental Health. *Utilization of Mental Health Facilities, 1971*, series B, No. 5, and unpublished data.

Table 10. Public Institutions for the Mentally Retarded: 1950-1971.[48]

[Preliminary data as submitted by many State agencies; therefore, in many instances figures reflect estimates rather than substantiated figures. For example, resident patients at the end of a year do not equal the number at the beginning of a succeeding year. Includes estimates for underreporting wherever possible. See also *Historical Statistics, Colonial Times to 1970*, series B 428–443]

ITEM	1950	1960	1965	1968	1969	1970	1971
Number of institutions	90	108	143	170	180	190	190
Resident patients, beginning of year	103,377	158,682	181,549	193,121	192,848	189,956	185,855
Admissions, excluding transfers	10,369	14,701	17,300	14,688	14,868	14,985	15,370
First admissions	9,382	13,534	15,033	12,359	12,226	12,075	11,200
Readmissions	987	1,167	2,267	2,329	2,642	2,910	4,170
Patients under treatment	113,746	173,383	198,849	207,809	207,716	204,941	201,225
Deaths in institutions	1,971	3,202	3,583	3,614	3,621	3,496	3,133
Net live releases [1]	4,681	6,451	7,993	11,675	14,701	14,702	17,080
Resident patients, end of year	107,094	163,730	187,273	192,520	189,394	186,743	180,963
Rate per 100,000 population [2]	71.0	91.9	97.7	97.7	95.1	92.6	88.6
Average daily resident patients	127,830	163,282	189,172	193,690	191,363	187,897	181,058
Personnel, full-time, total [3]	25,744	54,277	79,056	100,804	107,737	117,327	118,909
Rate per 100 average daily resident patients	20.1	33.2	41.8	52.0	56.3	62.4	65.7
Maintenance expenditures [3] [4] ....mil. dol.	92	266	442	673	765	871	1,003
Per average daily resident patient:							
Per year ....dol.	746	1,650	2,335	3,472	3,996	4,635	5,537
Per day ....dol.	2	5	6	9	11	13	15

[1] Excess of patients released alive from hospital over those returning to hospital.
[2] Based on Bureau of the Census estimated civilian population as of July 1.
[3] Reporting facilities only. [4] Includes salaries and wages, purchased provisions, fuel, light, water, etc.

Source: U.S. Social and Rehabilitation Service, *Residents in Public Institutions for the Mentally Retarded*, annual.

Table 11. Patients in Mental Care Facilities, 1971, 1973, and 1974.[49]

ITEM AND STATE	MENTAL HOSPITALS				Out-patient psychiatric services, admissions, 1973 [3]	General hospitals with psychiatric service, discharges, 1973 [3]	PUBLIC INSTITUTIONS FOR MENTALLY RETARDED, 1971 [4]		
	Private, 1973		Private, 1974						
	Resident patients, end of year	Total additions [1]	Resident patients, end of year	Total additions [1]			Resident patients, end of year	Total admissions	Net live releases [5]
Facilities, number	177		323		2,228	684		190	
United States	10,977	109,516	[6] 215,573	[6] 433,663	1,209,271	455,619	181,009	15,370	17,080
Alabama	75	2,093	3,067	3,830	8,069	5,870	2,213	106	57
Alaska	–	–	147	646	809	–	102	26	33
Arizona	20	179	770	1,564	10,588	5,574	954	35	42
Arkansas	–	–	493	2,485	3,363	1,156	1,262	94	35
California	1,225	14,877	9,175	27,412	139,259	35,254	10,494	731	1,466
Colorado	186	2,361	1,260	6,097	12,733	4,370	2,050	115	154
Connecticut	593	1,868	3,450	14,486	22,147	5,460	3,961	910	961
Delaware	–	–	998	2,208	3,015	59	570	37	30
Dist. of Columbia	114	762	3,039	5,438	6,919	4,062	1,202	105	125
Florida	371	7,345	[6] 6,507	7,117	25,939	21,120	6,172	452	338
Georgia	288	6,247	7,813	23,477	25,554	10,684	2,034	472	281
Hawaii	–	–	[6] 209	[6] 597	5,781	1,104	761	49	20
Idaho	–	–	245	1,141	374	196	586	99	87
Illinois	429	4,457	8,079	25,463	84,275	27,831	6,669	525	1,569
Indiana	21	424	4,878	8,847	15,721	19,502	3,521	173	193
Iowa	–	–	1,227	5,817	16,195	8,027	1,552	134	193
Kansas	232	586	1,547	4,818	12,731	4,729	2,012	265	232
Kentucky	341	4,580	1,047	1,921	1,861	8,955	982	179	176
Louisiana	272	3,125	2,851	9,279	21,841	4,987	3,019	244	133
Maine	8	241	909	1,457	2,011	673	754	89	142
Maryland	600	2,199	5,702	13,367	28,758	4,769	3,258	599	498
Massachusetts	685	6,192	6,340	14,508	46,799	4,270	7,279	365	498
Michigan	533	5,587	6,099	15,650	75,459	14,909	10,966	358	945
Minnesota	–	–	4,375	7,747	27,959	15,401	3,991	275	563
Mississippi	21	827	4,057	6,355	768	1,041	1,398	139	61
Missouri	122	1,661	4,054	21,109	18,265	12,550	2,257	1,343	1,581
Montana	–	–	1,057	2,797	1,009	1,878	861	58	123
Nebraska	–	–	686	3,494	5,545	4,483	1,429	44	257
Nevada	19	201	332	867	1,227	1,776	(7)	(7)	(7)
New Hampshire	–	–	1,306	1,190	6,177	460	923	31	60
New Jersey	381	3,564	10,479	14,263	25,955	12,702	7,200	509	58
New Mexico	52	632	361	2,203	2,338	363	693	58	83
New York	925	5,570	39,843	36,398	213,638	61,794	25,847	911	993
North Carolina	192	1,097	5,092	16,795	17,660	8,417	4,862	542	417
North Dakota	–	–	609	2,000	–	1,924	1,326	74	209
Ohio	389	4,508	11,421	20,783	56,365	24,918	9,074	454	474
Oklahoma	44	839	2,464	7,169	28,894	5,782	1,916	197	187
Oregon	37	347	1,294	5,551	14,809	3,779	2,758	93	140
Pennsylvania	853	8,815	17,111	8,727	61,462	22,607	10,339	554	686
Rhode Island	123	1,003	1,741	4,716	5,924	805	859	58	42
South Carolina	–	–	4,695	5,228	4,578	3,915	3,628	461	408
South Dakota	–	–	718	1,835	5,089	1,394	1,172	144	148
Tennessee	125	1,477	4,562	10,035	18,869	6,421	2,852	283	156
Texas	456	4,347	9,018	25,015	36,285	31,862	11,818	1,649	705
Utah	–	–	310	534	4,482	3,306	897	95	77
Vermont	211	449	599	1,172	4,866	547	575	63	112
Virginia	661	6,850	7,301	14,560	17,662	10,817	3,686	309	194
Washington	47	1,258	1,309	3,394	27,355	5,782	3,386	383	679
West Virginia	47	1,092	3,065	4,514	5,264	2,564	469	30	14
Wisconsin	279	1,856	1,559	6,868	25,046	14,770	3,712	425	424
Wyoming	–	–	303	719	1,689	–	705	26	12

– Represents zero. [1] Includes returns from extended leave as well as first admissions and readmissions. [2] Excludes VA and federally funded community mental health centers. [3] Provisional data. Excludes VA. [4] Source: U.S. Social and Rehabilitation Service, *Residents in Public Institutions for the Mentally Retarded*, annual. [5] Excess of patients released alive from hospital (direct discharges plus leave placements) over those returning to hospitals. [6] Estimated. [7] No institutions for mentally retarded, patients requiring hospitalization receive care at State mental hospital.

Source: Except as noted, U.S. National Institute of Mental Health, *Provisional Patient Movement and Administrative Data, State and Local Mental Hospitals, In-Patient Services, July 1, 1973 to June 30, 1974, Statistical Note 114*; and unpublished data.

of medical research today is a small team, consisting of an experienced investigator and his or her immediate associates. Their most frequent habitat is the medical school or graduate school of a large university. A lesser number thrive in a few research-oriented hospitals and research institutes.

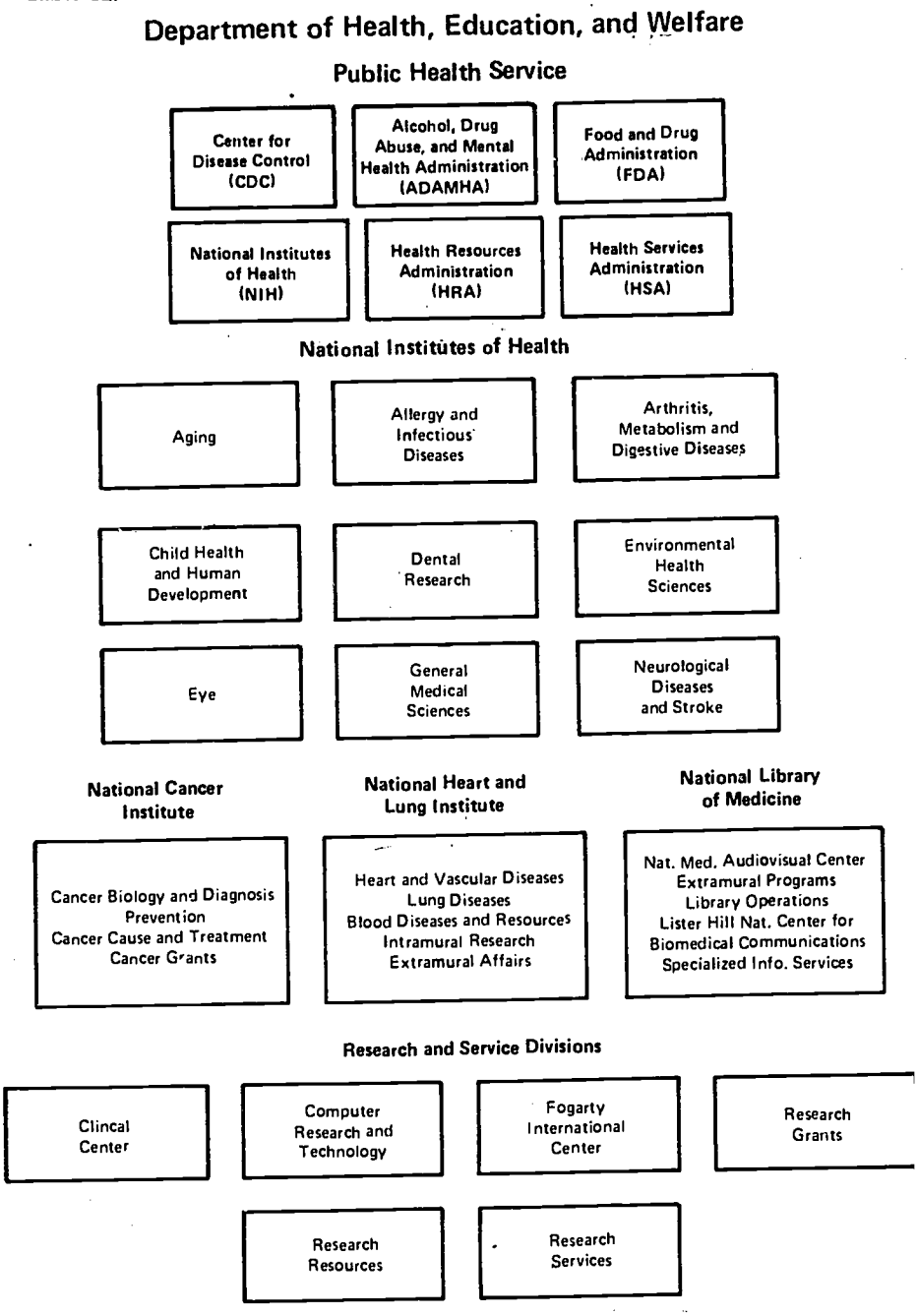
Almost all of the thousands of research projects currently underway are built around the research team, larger or smaller depending on the scope of the project. Their costs range from $5,000 to $500,000, with perhaps 90% of them costing between $15,000 and $100,000 per year. The total annual costs of these thousands of research projects plus the supporting services which maintain them has reached approximately $1 billion in the United States. This represents a spectacular expansion in less than two decades, and with rapid expansion has come awkward and patchwork organization.

In 1973, the Department of Health, Education, and Welfare (DHEW) made significant changes in the organization of its health programs, the effect of which was to consolidate those programs known collectively as the Public Health Service (PHS) into six major agencies, including the National Institutes of Health (NIH). The mandate of the NIH is to improve the health of the nation by increasing knowledge of health and disease through conducting and supporting research, research training, and biomedical communications. Biomedical research constitutes nearly 90% of federal health research and development, and most of it is carried out by the NIH. Close to 90% of the NIH budget goes to help support research and training in non-federal institutions. There are 44 review groups or study sections established to screen applications for scientific merit. There are now 11 institutes, including the new Institute on Aging. The largest in staff and budget is the Heart and Lung Institute. Together their budgets total more than that of all other institutes combined. The Institutes account for about 85% of the total NIH budget of $2 billion annually. Althought the NIH is the world's primary supporting agency for medical research, the costs of medical research are paid from a great variety of sources, including university endowments, individual and corporate gifts, foundations, public and voluntary agencies, and state legislatures.[50]

Table 12, which shows the organization of the PHS, may assist the debater in understanding the broad scope of the responsibility for the problems of health care which has been assumed by the federal government.

The Federal Drug Administration (FDA), created in 1938, tests all new drugs for safety before marketing is permitted.[52] It may ban drugs deemed too hazardous for public consumption, even with proper label warnings.[53] In 1962, efficacy requirements were established,[54] and a recent streamlining of efficacy testing reduces the time lag previously observed by drug concerns.[55] An additional modification involves publicity of moderately hazardous or questionable drugs when a full ban is not thought justified.[56]

Table 12. [51]


Department of Health, Education, and Welfare
Public Health Service
Center for Disease Control (CDC)
Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA)
Food and Drug Administration (FDA)
National Institutes of Health (NIH)
Health Resources Administration (HRA)
Health Services Administration (HSA)
National Institutes of Health
Aging
Allergy and Infectious Diseases
Arthritis, Metabolism and Digestive Diseases
Child Health and Human Development
Dental Research
Environmental Health Sciences
Eye
General Medical Sciences
Neurological Diseases and Stroke
National Cancer Institute
Cancer Biology and Diagnosis
Prevention
Cancer Cause and Treatment
Cancer Grants
National Heart and Lung Institute
Heart and Vascular Diseases
Lung Diseases
Blood Diseases and Resources
Intramural Research
Extramural Affairs
National Library of Medicine
Nat. Med. Audiovisual Center
Extramural Programs
Library Operations
Lister Hill Nat. Center for Biomedical Communications
Specialized Info. Services
Research and Service Divisions
Clincal Center
Computer Research and Technology
Fogarty International Center
Research Grants
Research Resources
Research Services

Ill Health in the United States

Debaters in 1977 should become quite familiar with information from the National Center for Health Statistics (NCHS), located in Rockville, Maryland. A division of the PHS, the NCHS produces data from the National Health Survey (NHS). The NCHS publishes a series of statistical reports based on information collected from a continuing nationwide sample of households in the Health Interview Survey (HIS).

"The Health Interview Survey utilizes a questionnaire which obtains information on personal and demographic characteristics, illnesses, injuries, impairments, chronic conditions, and other health topics. As data relating to each of these various broad topics are tabulated and analyzed, separate reports are issued which cover one or more of the specific topics."[57]

The methodology in the HIS appears excellent, following a multistage probability design which samples 376 primary units from 1,900 geographically defined units covering the fifty states and the District of Columbia. Like all studies, however, there is some chance of error. Each report of the NHS incorporates information relating to the reliability of the estimates. Advanced debaters might wish to probe into this question when attempting to base their arguments upon fluctuations observed in the incidence of disease. Similarly, slight shifts observed in charts might well be artifacts of the sampling methods, and negative arguments drawn from this possibility might be useful during the season.[58]

When do citizens of the United States need health care? From the broadest perspective, there is no point from the moment of inception until the moment that life stops when health care would be inappropriate. This frame of reference would incorporate the full spectrum of preventative care, from the minor irritations of the otherwise healthy person, through any episode of illness, to the onset of old age, and even into death, when organs might be used for transplants.

The material within this unit is divided into three categories: (1) preventative treatment for health, (2) the major illnesses, and (3) less serious illnesses. Drawing upon the data available, it is possible to establish some general estimate of the reasons people are not as healthy as they might be in the United States.

Preventative Treatment

There is a general lack of efficiency and utility in the nutrition programs of the present health care system. According to a recent report issued by the Senate Select Committee on Nutrition and Human Needs, nutrition training in medical schools is inadequate, there are not enough nutritionists and dieticians to serve the nation's needs, the federal government's means of measuring nutritional adequacy in the American diet are spotty and inefficient, and there are no effective mechanisms in the executive branch for dealing with these problems. Moreover, the mechanisms that do exist are designed to deal with the issue in economic, political, and foreign-policy terms, rather than in terms of the health impact of America's

domestic and foreign food policies.[59] Similarly, even when physicians are aware of the importance of nutrition as a discipline, they are unable to translate nutrition into foods and their relation to habits and patterns of various socioeconomic and ethnic groups or into the nuances of microeconomics and food distribution within the family.[60]

The predominant victims of deficiency diseases and diseases caused by malnutrition are the poor, the class least likely to be seen routinely by physicians. When the poor finally receive medical treatment, usually very late in the natural history of the disease process, the nutritional factors in the etiology and pathogenesis of their health problems may be camouflaged by other, more dramatic medical conditions that have also gone untreated, and the underlying malnutrition may be disregarded.[61] More specifically, nutritional insufficiency takes a particular toll on poor people, contributing to infant mortality and severe childhood diseases, while limiting learning ability, growth, and the capacity to concentrate on productive tasks. Unexpected effects also occur, such as a high incidence of learning-hampering iron deficiency in black children between the ages of one and five among families with incomes above the poverty line, and a high incidence of protein deficiency in white adults between the ages of 45 and 59.[62]

Vitamin programs, like nutritional programs, have been treated with ignorance in many cases under the present system. Physicians have long used vitamins in the prevention and treatment of diseases, but the present use of megavitamin therapy—prescription of excessive doses of vitamins—and its possible consequences pose danger to the patient, such as hypervitaminosis (toxicity). As Dr. H.N. Ross says, "too many physicians have attempted to use megavitamins by giving inadequate doses of a few vitamins to the wrong people for an insufficient amount of time only to achieve the failure that could be predicted."[63] Drs. Levy and Rita believe that orthomolecular medicine—megavitamin therapy in mental diseases—particularly as it uses megadoses of vitamins, is an experimental, unproven, and potentially dangerous form of therapy for any disease.[64] The fact that Americans spend 300 million dollars a year on vitamins, however, proves that the initiative for vitamin consumption lies mostly in the hands of the public.[65] This vitamin phenomenon is undoubtedly spurred by the production companies which advertise the health improvement that vitamins will bring. Though vitamin supplements are needed in certain conditions, such as pregnancy and old age, ignorance and abuse has resulted in many cases of toxicity, with the FDA's National Clearinghouse for Poison Control Center reporting about 4,000 cases of vitamin poisoning each year, 80% of them involving children.[66] On the other end of the continuum, vitamin deficiencies of A and D occur in certain areas of the nation.[67] Many of the elderly recuperating in hospitals and nursing homes lack adequate vitamin intake because of overcooked hospital food.[68]

Another area of preventative medicine, vaccinations, is presently in a regressive state; as a consequence, many individuals, notably children, are

not immunized against disease. According to Dr. Edwin D. Kilbourne, the present vaccine policy is not carried out in practice. For example, the policy recommends the preferential immunization, even in interpandemic years, of the estimated 45 million Americans who are unusually susceptible to influenza complications (pneumonia and death). But only about 20 million doses of vaccine are produced annually, and of this amount less than half reaches the high-risk population. Kilbourne continues by saying that present vaccines, which are 70% to 90% effective for about one year, have never been systematically or widely used during pandemics. "If only individuals abnormally susceptible to fatal complications (those over 65 years of age and those with cardiac or pulmonary disease) were selectively immunized, many of the predictable thousands of deaths and millions of illnesses could be prevented."[69]

U.S. News and World Report recently reported that certain diseases, such as measles and gonorrhea, are gaining ground because of new resistant strains and a letdown in vaccinations. It reports that millions of American children are unprotected from diseases, with one in three children not having been given shots that would immunize them against measles, polio, and rubella and one in two not having been immunized against mumps. According to Dr. David J. Sencer, director of the United States Center for Disease Control, "many diseases that are now endemic [confined locally] could easily reach epidemic levels if we relaxed our vigil, with so many people not vaccinated."[70] Dr. Theodore Cooper, Assistant Secretary for Health in DHEW, told government doctors that one of the reasons for the current low level of vaccination was the "increased reluctance" of the country's big pharmaceutical firms to help develop and make vaccines.[71]

As in other areas of preventative efforts, the victims of vaccine inadequacy are poor. Dr. John J. Witte, director of the immunization division of the United States Center for Disease Control, has stated that nearly all of the present cases are of unimmunized children, many from low-income neighborhoods where parents often fail to take their children to local health centers for their infancy vaccinations. Currently, health officials say that 34% of all preschool children and 31% of all children under fourteen years of age have not had a measles vaccination, leaving 13.8 million youngsters susceptible to a disease that could cause deafness, blindness, brain disease, and death.[72] Similarly, vaccines for diseases such as hepatitis, gonorrhea, flu, and pneumonia are still in developmental stages.[73]

Exercise therapy is a fourth type of preventative effort to control disease. The prescription for exercises has taken the place of many passive forms of treatment in total patient care since World War II, with the prescription for exercise based upon the physician's knowledge of the patient's condition as a whole and used in conjunction with whatever medical and surgical measures are necessary.[74] Exercise therapy is used in orthopedic, neurological, and general medical and surgical conditions. Orthopedic exercise corrects such conditions as back pain, posture deviations, bursitis, and

lumbago; neurological use of exercise corrects peripheral nerve injuries, multiple sclerosis, cerebral palsy, and paraplegia; and general medical use of exercise corrects cardiovascular, respiratory, and digestive problems, as well as arthritis and rheumatism. It has been reported that prolonged bed rest and complete absence from normal activity can spur problems such as hypostatic pneumonia, pulmonary congestion and collapse, embolism, lung edema, atrophy of bone, muscle and skin wasting, and phlebitis.[75] There is a strong correlation between physical exertion and better health, but the main problem lies in the application of certain exercises for certain conditions. One of the most important causes for the ineffectiveness of an exercise program lies within the realm of poor prescription in that each type of exercise has a unique physiological effect and, thus, a different therapeutic objective. Exercise variables to be considered are the precautions, duration, evaluation, nature of movement, range of movement, rhythm, timing, progression, and intensity of stress.[6] In addition, certain considerations must be accounted for before establishing exercise programs, among them the stability of the patient's condition, whether the exercise will affect the underlying illness or whether the illness will affect the ability to exercise, and whether prescribed medication will affect the exercise or whether the exercise will modify the drug's action. Therapeutic exercise programs are still in a developmental state because of these variables.[77]

Another view of preventative care, provided by material from the *Statistical Abstract* (see Table 13), indicates the incidence of chest x-rays,

Table 13: Selected Preventive Care Services: 1973.[78]

ITEM	BOTH SEXES			MALE			FEMALE		
	Population (1,000)	Percent with—		Population (1,000)	Percent with—		Population (1,000)	Percent with—	
		Care at any time	Care in past year		Care at any time	Care in past year		Care at any time	Care in past year
CHEST X-RAY									
Total, 17 years and over	141,802	80.1	31.2	66,641	80.3	31.9	75,161	80.0	30.7
17-39 years	67,854	76.5	28.8	32,724	76.4	28.8	35,129	76.7	28.8
40-64 years	53,696	85.1	34.1	25,531	84.7	35.2	28,165	85.6	33.1
65 years and over	20,253	78.9	31.7	8,386	82.4	33.5	11,867	76.5	30.5
EYE EXAMINATION									
Total, 3 years and over	195,775	87.7	41.3	94,109	85.7	41.4	101,666	89.6	41.3
3-16 years	53,972	79.7	60.3	27,467	78.9	59.4	26,505	80.5	61.3
17-39 years	67,854	88.8	33.1	32,724	86.5	33.6	35,129	90.9	32.7
40-64 years	53,696	92.0	35.4	25,531	89.7	35.2	28,165	94.1	35.7
65 years and over	20,253	94.0	33.8	8,386	92.6	31.7	11,867	95.0	35.3
BREAST EXAMINATION									
Total, 17 years and over	141,802	42.7	25.4	(X)	(X)	(X)	75,161	76.3	48.6
17-39 years	67,854	41.0	29.7	(X)	(X)	(X)	35,129	79.1	57.4
40-64 years	53,696	42.0	23.3	(X)	(X)	(X)	28,165	80.1	44.4
65 years and over	20,253	34.6	16.7	(X)	(X)	(X)	11,867	59.1	29.1

X Not applicable.

Table 14. Persons Wearing Corrective Lenses: 1971.[79]

[In thousands, except percent. Data refer to civilian noninstitutional population 3 years old and over. Based on sample and subject to sampling variability; see source. Excludes sunglasses worn only to filter light, safety glasses worn only for protection of the eyes, hand magnifying glasses, and other such devices]

ITEM	Total	SEX		AGE (in years)			
		Male	Female	3–16	17–24	25–44	45 and over
Population, 3 years old and over	191,602	92,121	99,481	55,786	27,275	47,428	61,113
Wearing lenses	94,284	40,757	53,527	9,249	11,114	19,978	53,944
Eyeglasses only	90,313	39,669	50,644	8,920	9,306	18,555	53,532
Contact lenses (with or without eyeglasses)	2,403	654	1,750	138	1,140	819	306
Percent wearing lenses	49.2	44.2	53.8	16.6	40.7	42.1	88.3
Eyeglasses only	47.1	43.1	50.9	16.0	34.1	39.1	87.6
Contact lenses (with or without eyeglasses)	1.3	0.7	1.8	0.2	4.2	1.7	0.5

Source: U.S. National Center for Health Statistics, *Vital and Health Statistics*, series 10–No. 79, and unpublished data.

eye examinations, and breast examinations. Eyeglasses, another form of preventative care, are worn by a substantial portion of our population. The incidence is expressed in Table 14.

Major Illnesses

We are accustomed to discussing the "major killers" when we talk about disease. Heart and cancer problems have been the leading causes of death since the 1940s in the United States. According to information published by the National Heart and Lung Institute, the ten leading causes of death in 1970 were as follows: (1) diseases of the heart, (2) malignant neoplasms, including neoplasms of lymphatic and hemotopoietic tissues, (3) cerebrovascular diseases, (4) accidents, (5) influenza and pneumonia, (6) certain causes of mortality in early infancy, (7) diabetes melitus, (8) arteriosclerosis, (9) cirrhosis of the liver, and (10) bronchitis, emphysema, and asthma.[80] Provisional causes of death in 1975 were listed in Table 15, which is included in the *World Almanac of 1977*. The major cause of death in the United States, heart, blood vessel and blood diseases, accounted for more than one-third of the deaths in 1975.

A substantial amount of data is available from the National Center for Health Statistics. *Vital Statistics Rates in the United States 1900-1960* (PHS Pub. No. 1677), for example, provides significant breakdowns of the sort of data included in Table 15.

Following is a brief description of eleven categories which are major causes of death:

Atherosclerosis. Each year in the United States one million persons die as a result of cardiovascular disease, and 84% of these deaths are attributable to atherosclerosis. Coronary heart disease, stroke, and occlusive disease of the aorta and peripheral vessels are all caused by atherosclerosis.[82]

Hypertension. Approximately 22 million Americans, or between 10% and 15% of the population, have high blood pressure. The prevalence in the black population is probably 30%. Hypertension is important because

Table 15. Deaths and Death Rates for Selected Causes.*[81]

Source: Division of Vital Statistics, National Center for Health Statistics.
Rates per 100,000 population

1975* Cause of death	Number	Rate	1975* Cause of death	Number	Rate
All causes	1,910,000	888.1	Acute bronchitis and bronchiolitis	820	0.4
Enteritis and other diarrheal diseases	1,920	0.9	Influenza and pneumonia	57,520	27.0
Tuberculosis, all forms	3,300	1.5	Influenza	4,780	2.2
Syphilis and its sequelae	360	0.2	Pneumonia	52,740	24.7
Other infective and parasitic diseases	3,630	1.7	Bronchitis, emphysema, and asthma	25,300	11.9
Malignant neoplasms, including neoplasms of lymphatic and hematopoietic tissues	371,660	174.4	Chronic and unqualified bronchitis	4,860	2.3
			Emphysema	18,410	8.6
			Asthma	2,040	1.0
Diabetes mellitus	35,860	16.8	Peptic ulcer	6,840	3.2
Meningitis	1,820	0.9	Hernia and intestinal obstruction	6,440	3.0
Major cardiovascular diseases	979,180	459.4	Cirrhosis of liver	32,080	15.1
Diseases of heart	722,570	339.0	Cholelithiasis, cholecystitis and cholangitis	3,000	1.4
Active rheumatic fever and chronic rheumatic heart disease	12,460	5.8	Nephritis and nephrosis	8,410	3.9
			Infections of kidney	4,420	2.1
Hypertensive heart disease with or without renal disease	11,200	5.2	Hyperplasia of prostate	1,290	0.6
			Congenital anomalies	14,380	6.7
Ischemic heart disease	648,540	304.3	Certain causes of mortality in early infancy	27,350	12.8
Chronic disease of endocardium and other myocardial insufficiency	4,720	2.2	Symptoms and ill-defined conditions	32,610	15.3
			All other diseases	119,090	55.9
All other forms of heart disease	45,650	21.4	Accidents	101,400	47.6
Hypertension	6,370	3.0	Motor vehicle accidents	44,570	20.9
Cerebrovascular diseases	195,630	91.8	All other accidents	56,830	26.7
Arteriosclerosis	29,230	13.7	Suicide	26,960	12.6
Other diseases of arteries arterioles, and capillaries	25,380	11.9	Homicide	21,730	10.2
			All other external causes	4,940	2.3

Due to rounding estimates of death, figures may not add to total. *Provisional.
Data based on a 10% sampling of all death certificates for a 12-month (Jan.-Dec.) period.

it is a major cause of death and disability and especially because effective treatment is now available.[83]

Heart Attack. Myocardial Infarction and Angina Pectoris. Each year over one million Americans have a heart attack (acute myocardial infarction). As a result, 375,000 die.[84]

Heart Failure. At least one and one-half million Americans suffer from chronic heart failure, and approximately one-quarter of a million new cases occur each year. The problem is large in terms of disability, with between 300,000 and 600,000 patients admitted to hospitals each year with this condition. Heart failure is an important manifestation or consequence of a variety of diseases of the heart, including coronary artery disease, hypertension, and rheumatic and congenital heart disease.[85]

Emphysema and Chronic Bronchitis. These are common and still increasing causes of death and disability in this country. Approximately 100,000 work-years are lost annually to the labor force.[86]

Lung Disease of Infancy and Early Childhood. Hyaline membrane disease affects about 50,000 infants a year. Half of these children are likely to die unless they receive specialized therapy.[87]

Cystic Fibrosis. A genetically determined disease and one of the main causes of chronic illness in children and young adults, cystic fibrosis occurs in one out of every two thousand live births and accounts for most deaths from chronic pulmonary disease in pediatric patients.[88]

Congenital Heart Disease. It is estimated that 8 out of every 1,000 newborn infants have congenital heart disease. Half of the children born with congenital heart disease do not reach their first birthday, and 90% of the half who die in the first year do so within the first six months of life, most of these by the third month. The neonatal time is the time of greatest risk.[89]

Hemophilia and other hemorrhagic diseases. There are at least 25,000 patients with moderate or severe hemophilia in the United States. The disease constitutes a major health problem for two special reasons: (1) the disease bankrupts the patient and his family economically and emotionally, and (2) therapy, currently based upon the use of plasma fraction obtained from human blood, represents one of the greatest single demands on the nation's blood resources.[90]

Sickle Cell Disease and the Hemoglobinopathies. Inherited illnesses which affect the red blood corpuscles of large numbers of Americans exist. One out of every 400 blacks is born with sickle cell anemia, the most common and serious of these diseases.[91]

Hepatitis. Hepatitis is the most frequent serious complication encountered in transfusing blood and blood products. Post-transfusion hepatitis is estimated to occur annually in 20,000 to 30,000 patients and to be fatal in about 3,000. There are approximately 500,000 to 1 million chronic carriers of the hepatitis virus in this country.[92]

A different type of death, that caused by accidents, is the number four "killer" in the United States. Table 16 provides data on this cause of death.

Less Serious Illnesses

Lest the label mislead, the illnesses discussed below are serious. The distinction made herein is merely the focus upon continued care, rather than upon death. The PHS reported in 1974 on the incidence of acute conditions in the United States. Table 17 reports those data. The

Table 16. Principal Types of Accidental Deaths.[93]

Source: Division of Vital Statistics, National Center for Health Statistics.

Year	All types	Motor vehicle	Falls	Burns	Drowning	Firearms	Machinery	Poison gases	Other poisons
1960	93,806	38,137	19,023	7,645	6,529	2,334	1,951	1,253	1,679
1965	108,004	49,163	19,984	7,347	6,799	2,344	2,054	1,526	2,110
1970	114,638	54,633	16,926	6,718	6,391	2,406		1,620	3,679
1972	115,448	56,278	15,744	6,714	6,196	2,442		1,690	3,728
1973	115,821	55,511	16,506	6,503	7,152	2,610		1,652	3,683
1974	104,622	46,402	16,339	6,236	6,463	2,513		1,518	4,018
1975	101,400	44,570	NA	NA	NA	NA	NA	NA	NA
Death Rates per 100,000 Population									
1960	52.1	21.2	10.6	4.2	3.6	1.3	1.1	0.7	0.9
1965	55.7	25.4	10.3	3.8	3.5	1.2	1.1	0.8	0.1
1970	56.4	26.9	8.3	3.3	3.1	1.2		0.8	1.8
1972	55.4	27.0	8.0	3.2	3.0	1.2		0.8	1.8
1973	55.2	26.5	7.9	3.1	3.4	1.2		0.8	1.7
1974	49.5	22.0	7.7	2.9	3.1	1.2		0.7	1.9
1975	47.8	20.9	NA	NA	NA	NA	NA	NA	NA

Accidental Injuries by Severity of Injury

Source: National Safety Council

1975 Severity of Injury	Total*	Motor-Vehicle	Work	Home	Public Non-Motor-Vehicle
All Injuries*	10,800,000	1,850,000	2,200,000	4,050,000	2,800,000
Deaths	102,500	46,000	12,600	25,500	22,500
Nonfatal injuries	10,700,000	1,800,000	2,200,000	4,000,000	2,800,000
Permanent impairments	380,000	150,000	80,000	100,000	70,000
Temporary total disabilities	10,300,000	1,650,000	2,100,000	3,900,000	2,700,000
Certain Costs of Accidental Injuries, 1975 ($ billions)					
Total*	$47.1	$21.2	$18.0	$6.0	$4.8
Wage loss	15.4	7.1	3.4	2.0	2.9
Medical expense	8.2	1.9	1.7	1.8	1.1
Insurance admin., costs	6.3	4.2	1.9	0.1	0.1

*Duplication between motor-vehicle, work and home are eliminated in the Total column.

Table 17. Incidence of Acute Conditions and Number of Acute Conditions per 100 Persons per Year, by Age, Sex, and Condition Group: 1974.[94]

[Data are based on household interviews of the civilian, noninstitutionalized population. The survey design, general qualifications, and information on the reliability of the estimates are given in appendix I. Definitions of terms are given in appendix II]

SEX AND CONDITION GROUP	ALL AGES	UNDER 6 YEARS	6-16 YEARS	17-44 YEARS	45 YEARS & OVER	ALL AGES	UNDER 6 YEARS	6-16 YEARS	17-44 YEARS	45 YEARS & OVER
	INCIDENCE OF ACUTE CONDITIONS IN THOUSANDS					NUMBER OF ACUTE CONDITIONS PER 100 PERSONS PER YEAR				
BOTH SEXES										
ALL ACUTE CONDITIONS	364,278	61,121	102,172	141,483	59,503	175.7	309.0	236.7	175.1	93.6
INFECTIVE AND PARASITIC DISEASES	40,465	9,371	13,062	12,958	5,074	19.5	47.4	30.3	16.0	8.0
RESPIRATORY CONDITIONS	195,741	34,149	56,671	74,696	30,225	94.4	172.6	131.3	92.5	47.5
UPPER RESPIRATORY CONDITIONS	94,868	20,233	27,982	33,134	13,520	45.8	102.3	64.8	41.0	21.3
INFLUENZA	92,809	11,928	27,228	39,685	14,968	44.8	60.3	63.1	47.9	23.5
OTHER RESPIRATORY CONDITIONS	8,065	1,987	1,462	2,878	1,738	3.9	10.0	3.4	3.6	2.7
DIGESTIVE SYSTEM CONDITIONS	16,193	1,440	4,598	7,076	3,070	7.8	7.3	10.6	8.8	4.8
INJURIES	63,085	6,697	16,429	27,277	12,682	30.4	33.9	38.1	33.8	19.9
ALL OTHER ACUTE CONDITIONS	48,794	9,455	11,412	19,476	8,452	23.5	47.8	26.4	24.1	13.3

Table 18. Specified Reportable Diseases—Cases Reported: 1950-1973.[95]

[Prior to 1960, excludes Alaska and Hawaii, except for tuberculosis. Figures should be interpreted with caution. Although reporting of some of these diseases is incomplete, the figures are of value in indicating trends of disease incidence. See *Historical Statistics, Colonial Times to 1970*, series B 291-304 for related data]

DISEASE	1950	1955	1960	1965	1969	1970	1971	1972	1973
Amebiasis	4,568	3,348	3,424	2,768	2,915	2,888	2,752	2,190	2,235
Aseptic meningitis	(NA)	(NA)	1,593	2,329	3,672	6,480	5,176	4,634	4,846
Botulism	20	16	12	19	16	12	25	22	34
Brucellosis (undulant fever)	3,510	1,444	781	262	235	213	183	196	202
Diphtheria	5,796	1,984	918	164	241	435	215	152	228
Encephalitis: Primary infectious	1,135	2,166	2,341	1,722	1,613	1,580	1,524	1,059	(NA)
Post-infectious				991	304	370	439	243	(NA)
Hepatitis: Serum (Hepatitis B)	2,820	31,961	41,666	33,856	5,909	8,310	9,556	9,402	8,451
Infectious (Hepatitis A)					48,416	56,797	59,606	54,074	50,749
Leprosy	44	75	54	96	98	120	131	130	146
Leptospirosis	(NA)	24	53	84	80	47	62	41	57
Malaria	2,184	522	72	147	3,102	3,051	2,375	742	237
Measles	319	555	442	262	26	47	75	32	27
Meningococcal infections	3,788	3,455	2,259	3,040	2,051	2,505	2,262	1,323	1,378
Pertussis (whooping cough)	120,718	62,786	14,809	6,799	3,285	4,249	3,036	3,287	1,759
Poliomyelitis, acute	33,300	28,985	3,190	72	20	33	21	31	8
Psittacosis	26	334	113	60	57	35	32	52	33
Rabies in animals	[1] 7,901	5,799	3,567	4,574	3,490	3,224	4,310	4,369	3,640
Rheumatic fever, acute [2]	(NA)	(NA)	9,022	4,998	3,229	3,227	2,793	2,614	2,560
Rubella (German measles)	(NA)	(NA)	(NA)	(NA)	57,686	56,552	45,086	25,507	27,904
Salmonellosis, excl. typhoid fever	1,233	5,447	6,929	17,161	19,419	22,096	21,928	22,151	23,818
Shigellosis (bacillary dysentery)	23,367	13,912	12,487	11,027	11,946	13,845	16,143	20,207	22,642
Streptococcal sore throat and scarlet fever	64	148	315	395	450	433	(NA)	(NA)	(NA)
Tetanus	486	462	369	300	185	148	116	128	101
Trichinosis	327	264	160	199	222	109	103	89	102
Tuberculosis (newly reported active cases)	(NA)	76,245	55,494	49,016	39,120	37,137	35,217	32,882	31,015
Tularemia	927	584	390	264	149	172	187	152	171
Typhoid fever	2,484	1,704	816	434	364	346	407	398	380
Typhus fever:									
Flea-borne (endemic-murine)	685	135	68	28	36	27	23	18	32
Tick-borne (Rocky Mountain spotted fever)	54	295	204	291	498	380	432	523	668
Venereal diseases (civilian cases):									
Gonorrhea	297	236	259	325	535	600	670	787	843
Syphilis	218	122	122	113	92	91	96	91	87
Other	8.2	3.9	2.8	2.0	1.8	2.2	2.1	2.3	1.6

NA Not available. [1] Figures from U.S. Dept. of Agriculture, Economic Research Service.
[2] Based on reports from States; 37 in 1960 and 1969; 36 in 1965, 1971, and 1973; 38 in 1970; and 35 in 1972.

Source: U.S. National Center for Health Statistics, *Vital Statistics—Special Reports*, vol. 37, No. 9, and U.S. Center For Disease Control, Atlanta, Ga., *Morbidity and Mortality Weekly Report* (annual supplements), vol. 13, No. 54, and vol. 22, No. 53.

categorization employed in Table 17 is of special interest. A much broader categorization appears in Table 18. Debaters would need to choose materials from the proper set of data to have specific effect in arguments.

One frequent impact of illnesses such as those mentioned in these two tables is a short stay in the hospital. In 1974 there were 221 million hospital days attributed to persons with one, two, or three hospital stays during the year.[96] One-quarter of these days were by persons over 65 years old; almost one-third of the days were by persons between 45 and 64 years of age.[97]

Health Professionals

In 1970, there were over 1.3 million health professionals working in the United States, according to a DHEW report.[98] Of this number, 323,200 were physicians, 102,220 were dentists, and the remaining number were distributed among registered nurses, optometrists, pharmacists, podiatrists, and veterinarians. The two largest groups were nurses (54.4%) and physicians (24.3%).[99]

A 1973 breakdown of active physicians into type of practice and primary

specialties yields a clearer view of the distribution of our practicing physicians (see Table 19).

In 1974, there were 857,000 total registered nurses in practice, 608,000 full time. The number of nursing school students was 232,589. The population/nurse ratio in 1974 was 1:246; a favorable trend from 1970, when the ratio was 1:281.[101]

Dr. Kenneth M. Endicott, an Assistant Surgeon General in the PHS, is Administrator of the Health Resources Administration of DHEW. In an essay included in *Health in America: 1776-1976*, Dr. Endicott noted:

> In 1976 the field of health and medical care will employ approximately 4.7 million workers, about 7 percent of the total work force in the United States. This manpower is distributed among a number of diverse occupational categories. Many of these categories, like the health industry itself, are in a rapid growth phase, as indeed are all service industries in this Second American Century. The growth will probably continue for several decades in response to change in the age distribution of the population, to technological advances, and probably to the anticipated enactment of national health insurance.[102]

Table 20 is the product of Dr. Endicott's work. He is responsible for the federal programs that support health personnel training and education programs.

Affirmative teams which choose to argue that there is a shortage of professionals in specialized categories must respond to another question: What ratio of specialist to patients would be cost-beneficial? Further, the debaters must question the geographic distribution of these specialists, for less population does not mean the specialty can be ignored.

One field omitted from the above discussions is chiropractics, the art and science of spine manipulation. The Office of Education has given the American Chiropractic Association recognition as an accrediting body for chiropractors, and Medicare and Medicaid have approved chiropractic treatment coverage; thus, the field of chiropractics should be a concern of debaters in 1977. In 1974, Mississippi legitimized the practice by beginning to license chiropractors, becoming the last of the states to take such action. Government research may be forthcoming, and additional concern may well be advisable for debaters.[104]

The system of health care in the United States once relied upon the general practitioner. That situation is no longer true. The various elements of the health profession as they relate to individuals who specialize must be considered in depth.

One area of concern to debaters this year is the necessity for health professionals to obtain malpractice insurance. The dimension of the problem for doctors is illustrated in data published on October 25, 1976, in the *New York Times*: "Malpractice insurance premiums vary widely according to a doctor's specialty, but, on the average, each doctor paid $1,905 a year for insurance in 1973. By 1975 the premiums had risen to an average of $7,787. The AMA said that the cost of malpractice insurance increased still further in 1976 and that the average doctor fee rose again."[105]

Table 19. Type of Practice and Primary Specialty of Active Physicians: United States, 1973.[100]

Primary specialty	Active M.D.s(Dec. 31, 1973)					
	Total[1]		Patient care			Other professional activity[2]
			Office-based practice	Hospital-based practice		
	Number	Percent		Training programs	Full-time physician staff	
Total	324,367	100.0	201,435	58,252	35,570	29,110
Percent	100.0	-	62.1	18.0	11.0	9.0
General practice[3]	69,823	21.5	51,220	8,504	5,335	4,764
Specialty practice	254,544	78.5	150,215	49,748	30,235	24,346
Medical specialties	86,924	26.8	48,689	19,333	9,576	9,326
Allergy	1,640	0.5	1,418	-	76	146
Cardiovascular diseases	6,159	1.9	4,345	-	815	999
Dermatology	4,340	1.3	3,188	623	268	261
Gastroenterology	1,983	0.6	1,348	-	257	378
Internal medicine	49,899	15.4	25,315	14,163	5,328	5,093
Pediatrics[4]	20,849	6.4	12,135	4,547	2,182	1,985
Pulmonary diseases	2,054	0.6	940	-	650	464
Surgical specialties	103,745	32.0	71,700	19,428	8,369	4,248
Anesthesiology	12,196	3.8	8,217	1,820	1,410	749
Colon and rectal surgery	658	0.2	602	27	15	14
General surgery	30,857	9.5	19,040	7,885	2,740	1,192
Neurological surgery	2,809	0.9	1,851	586	221	151
Obstetrics and gynecology	20,494	6.3	14,823	3,311	1,396	964
Ophthalmology	10,496	3.2	8,208	1,446	502	338
Orthopedic surgery	10,587	3.5	7,450	1,970	875	292
Otolaryngology	5,484	1.7	4,068	827	403	186
Plastic surgery	1,991	0.6	1,497	303	118	73
Thoracic surgery	1,875	0.6	1,283	264	213	115
Urology	6,298	1.9	4,661	987	476	174
Psychiatry and neurology	28,804	8.9	14,387	4,944	5,581	3,892
Child psychiatry	2,362	0.7	1,293	322	329	418
Neurology	3,741	1.2	1,614	941	542	644
Psychiatry	22,701	7.0	11,480	3,681	4,710	2,830
Other specialties	35,071	10.8	15,439	6,043	6,709	6,880
Aerospace medicine	779	0.2	220	43	173	343
General preventive medicine	769	0.2	212	50	51	456
Occupational medicine	2,374	0.7	1,639	7	73	655
Pathology[5]	11,498	3.5	3,782	2,638	2,811	2,267
Physical medicine and rehabilitation	1,569	0.5	554	286	572	157
Public health	2,737	0.8	531	40	151	2,015
Radiology[6]	15,345	4.7	8,501	2,979	2,878	987

1 Excludes 5,644 M.D.s with addresses unknown, 13,744 unclassified M.D.s, and an estimated 12,000 doctors of osteopathy, for whom recent data are not available.

2 Includes medical teaching, administration, research, and other.

3 Includes no specialty reported and other specialties not listed.

4 Includes pediatric allergy and pediatric cardiology.

5 Includes forensic pathology.

6 Includes diagnostic radiology and therapeutic radiology.

SOURCE: AMA Center for Health Services Research and Development: Distribution of Physicians in the United States, 1973. Regional, State, County, Metropolitan Areas. G.A. Roback, Chicago, American Medical Association, 1974.

Table 20. Estimated Persons Employed in Selected Occupations within Each Health Field: 1974.[103]

Health field and occupation	Active workers
Total [1]	4,672,850—4,707,650
Administration of health services	48,200
Administrator, public health dept	5,200
Hospital Administrator and assistant	17,000
Nursing home administrator and assistant	16,000
Voluntary health agency administrator and program representative	10,000
Anthropology and sociology	1,700
Cultural and physical anthropologist	700
Medical sociologist	1,000
Systems analysis, data processing	4,000—5,000
Basic research scientists in health fields [2]	60,000
Biomedical engineering	12,000
Biomedical engineer	4,000
Biomedical engineering technician	8,000
Chiropractors	16,600
Clinical laboratory services	172,500
Clinical laboratory scientist	5,500
Clinical laboratory technologist	97,000
Clinical laboratory technician and assistant	70,000
Dentistry and allied services	279,800
Dentist	107,300
Dental hygienist	22,500
Dental assistant	118,000
Dental laboratory technician	32,000
Dietetic and nutritional services	72,700
Dietitian and nutritionist	48,000
Dietetic technician and food service supervisor	24,700
Economic research in the health field	400
Environmental sanitation	20,000
Sanitarian	15,000
Technician and aide	5,000
Food and drug protective services	47,900
Inspector (health, food and drug, other)	16,400
Food and drug chemist, microbiologist	1,100
Food technologist	7,000
Food technician	3,400
Funeral directors and embalmers	50,000
Health and vital statistics	1,350
Health statistician	1,100
Vital record registrar	150
Demographer	100
Health education	22,500—23,000
Public health educator	2,500—3,000
School health educator, coordinator	20,000

Table 20. Continued

Health field and occupation	Active workers
Health information and communication	7,400—10,500
Biomedical photographer	2,000—3,000
Health information specialist and science writer	2,000—4,000
Medical writer	1,400
Technical writer and editor	1,500
Medical illustrator	500—600
Library services in the health field	10,300
Medical librarian	3,000
Medical library technician and clerk	7,300
Medical records	60,000
Registered record administrator	5,500
Accredited record technician	7,500
Other medical record personnel	47,000
Medicine and osteopathy	362,700
Physician (M.D.)	350,600
Physician (D.O.)	12,100
Midwifery	4,300
Lay midwife	2,500
Nurse-midwife	1,800
Nursing and related services	2,319,000
Registered nurse	857,000
Practical nurse	492,000
Nursing aide, orderly, attendant	936,000
Home health aide	34,000
Occupational therapy	13,500—14,500
Occupational therapist	8,000
Occupational therapy technician, assistant	5,500—6,500
Dispensing opticians	12,000
Optometry	25,100—25,300
Optometrist	19,300
Optometric assistant	5,000
Optometric technician	800—1,000
Orthotists and prosthetists	2,800—3,800
Pharmacists	132,900
Physical therapy	26,100
Physical therapist	18,000
Physical therapy technician, assistant	8,100
Podiatrists	7,100
Psychologists	35,000
Radiologic (X-ray) technologists, assistants	100,000
Respiratory therapists and technicians	18,000—19,000
Secretarial and office services in the health field	275,000—300,000
Social work	38,600
Medical and psychiatric social worker	34,300
Social work assistant and aide	4,300

Table 20. Continued

Health field and occupation	Active workers
Specialized rehabilitation services	11,250—13,250
Corrective therapist	1,100
Educational therapist	400
Manual arts therapist	1,000
Music therapist	2,200
Therapeutic recreational specialist	6,000—8,000
Home economist in rehabilitation	550
Speech pathologists and audiologists	27,000
Veterinary medicine	33,500
Veterinarian	28,500
Animal technician	5,000
Vocational rehabilitation counselors	17,700
Miscellaneous health services	323,950
Electrocardiograph technician	9,500
Electroencephalograph technician	4,000
Emergency medical technician	260,000
Medical assistant	16,000
Operating room technician	12,000
Ophthalmic medical assistant	20,000
Orthoptist	450
Physician's assistant	2,000

[1] Each occupation is counted only once. For example, all physicians are in medicine and osteopathy.

[2] Statistics are not available on what percentage of the estimated 250,000 physical scientists are employed in the health field.

According to an article in *Journal of American Insurance*, "without this professional liability insurance, especially today, the doctor cannot practice, the hospital cannot admit the patient, and the host of other health care providers cannot function."[106] The reason for this claim, according to the same article, is that "the patient is suing his doctor out of business."[107] The problem, according to Elizabeth Bowman, is worst for surgeons. In 1970, 57.2% of the suits were brought against various surgical specialists. An additional 20.5% were brought against general medical practitioners, and the remaining 22.3% of the suits were brought against radiologists, pathologists, and specialists for all other treatments.[108]

Much of the current legislation relating to medical malpractice rests with the state:

> A number of states have recently enacted legislation directed at the malpractice crisis. The new laws accomplish such things as clarifying judicial rules, providing for stricter statutes of limitation and creating mandatory review boards to examine malpractice cases before they go to trial in order to discourage frivolous suits. It is likely that most of these reforms will be largely ineffective in reducing malpractice awards.
>
> A few effective cost-containment laws have been enacted. They reflect two general approaches, exemplified by the statutes of Indiana and California. Indiana's law limits the liability of the "health-care provider" to $100,000. In addition a compensation fund was created by a charge of up to 10 percent of

the malpractice premiums paid by physicians and hospitals; the patient can receive compensation from the fund for as much as $400,000. Florida, Louisiana, Oregon, Wisconsin, Idaho, Pennsylvania and Illinois have followed this general approach. Unless a fund has no ceiling or a high one, however, the statute is vulnerable to the challenge that it is unconstitutional; a challenge of this kind has already been successful in the Supreme Court of Illinois.[109]

The situation relating to malpractice insurance for health professionals is currently in flux. The system which exists is one in which the individual is generally responsible for due care, and the application of strict liability standards is contingent upon the general standard of practice in a given specialty and area. There are a number of different state approaches to the problem, and the debater interested in this particular part of the problem area will want to study the statutes as well as case law so that effective arguments can be developed.

States have attempted solutions. But "the system for disciplining physicians set up by the New York State legislature in 1975 as part of an effort to stem the increase in malpractice suits has failed to weed out incompetent and unethical physicians, according to a report released yesterday by the New York State Consumer Protection Board."[110]

Despite efforts in 38 states and action of some sort in 7 more, "the search for viable solutions to approximately reflect the interests and concerns of all involved is expected to continue for some time and may well include efforts by some for federal relief as well."[111]

The same article notes that one prompt remedy which could be initiated lies within the power of the state courts to regulate attorney contingent fees and may provide some negative teams with an inherency argument.

Doctors believe that the cause for the problem is "the expansion of legal doctrines affecting malpractice suits [which] has made it easier for patients to collect awards."[112] This view of the problem, expressed in an analysis published in the *Congressional Quarterly Weekly Report* of April 5, 1975, notes that "traditionally, the plaintiff in a malpractice suit—the patient himself or a relative—must show under the torts procedure that he has been injured as a result of negligence on the part of a doctor or hospital. According to the HEW commission, however, legal precedents have made it easier for plaintiffs to establish negligence or collect awards without establishing negligence."[113]

Health Facilities and Treatment

Facilities

Patients are treated in offices, clinics, homes, and even at the scene of accidents. But the majority of the payments for medical care are made for treatment in hospitals. In 1973 there were 7,123 hospitals in the United States. Of this number, 5,891 were short-term, non-federal facilities. The short-term facility intends to care for individuals with acute illnesses, rather than to act as a nursing care facility. The occupancy rate for these

facilities was 77.5%. This occupancy rate meant that on any given day in 1973, there were 681,500 patients in these hospitals.[114]

The costs of maintaining hospital facilities are staggering. In 1973, the 7,123 hospitals maintained assets of $44.3 billion.[115] The facilities employed an average of 315 people for every 100 patients.[116] Like everything else involved with the health care system of the United States, hospitals are big business in our country.

Hospitals differ in intended service rendered, in profit expectation, and in who controls them. Some hospitals, as mentioned above, are intended for short stays. Other hospitals, such as those controlled by the Veterans Administration, are federally operated. There are state and local hospitals. There are private hospitals which are designed to make a profit, and others which are voluntary non-profit facilities. Some hospitals are operated by group insurance concerns, such as the Kaiser Permanente Plan, which originated in California. Table 21 provides a breakdown of the types of service and control for the hospital system in the United States.

The number of beds available in a given geographical area is important for several reasons. The most obvious, of course, is that unless a bed is

Table 21. Hospitals—Type of Service and Control: 1950-1973.[117]

[Prior to 1960, excludes Alaska and Hawaii. Covers hospitals accepted for registration by the American Hospital Association; see text, p. 50. Short-term hospitals have an average patient stay of 30 days or less; long-term, an average stay of longer duration. See also *Historical Statistics, Colonial Times to 1970*, series B 305-318 and B 331-344]

ITEM	1950	1960	1965	1968	1969	1970	1971	1972	1973
Hospitals	6,788	6,876	7,123	7,137	7,144	7,123	7,097	7,061	7,123
Beds	1,456	1,658	1,704	1,663	1,650	1,616	1,556	1,550	1,535
Rate per 1,000 population [1]	9.6	9.3	8.9	8.4	8.3	8.0	7.5	7.4	7.3
Occupancy rate [2]	86.0	84.6	82.3	82.9	81.6	80.3	79.5	78.0	77.5
TYPE OF SERVICE AND OWNERSHIP									
Federal hospitals, all types	414	435	443	416	415	408	407	401	397
Beds	189	177	174	175	170	161	148	143	142
Occupancy rate [2]	80.4	87.2	86.1	83.7	82.7	79.6	83.2	80.0	79.0
Non-Federal hospitals	6,374	6,441	6,680	6,721	6,729	6,715	6,690	6,660	6,726
Beds	1,266	1,481	1,530	1,480	1,480	1,455	1,408	1,407	1,392
Short-term general and special	5,031	5,407	5,736	5,820	5,853	5,859	5,865	5,843	5,891
Beds	505	639	741	806	826	848	867	884	903
Rate per 1,000 population [1]	3.3	3.6	3.9	4.1	4.1	4.2	4.2	4.2	4.3
Occupancy rate [2]	73.7	74.7	76.0	78.2	78.8	78.0	76.7	75.2	75.4
Long-term general and special	412	308	283	280	260	236	218	216	229
Beds	70	67	66	67	63	60	54	54	57
Occupancy rate [2]	85.7	86.9	85.3	82.6	82.5	82.0	83.4	83.0	82.1
Psychiatric	533	488	483	505	509	519	513	529	543
Beds	620	722	685	594	570	527	469	457	422
Occupancy rate [2]	97.9	93.1	88.6	89.6	85.9	84.8	83.8	82.8	81.1
Tuberculosis	398	238	178	116	107	101	94	72	63
Beds	72	52	37	22	20	20	18	13	10
Occupancy rate [2]	86.1	75.4	70.0	65.1	64.7	61.8	60.7	61.2	61.9
NON-FEDERAL OWNERSHIP OR CONTROL									
State hospitals	(3)	556	546	559	565	577	580	570	567
Beds	(3)	752	708	629	598	558	498	482	449
Occupancy rate [2]	(3)	91.8	87.5	88.2	84.4	83.3	82.2	81.6	80.0
Local government hospitals	[3] 1,654	[3] 1,321	1,405	1,631	1,665	1,680	1,700	1,730	1,756
Beds	[3] 844	201	216	219	220	219	219	219	218
Occupancy rate [2]	[3] 81.8	77.1	76.3	76.5	76.5	75.6	74.2	73.0	72.8
Nongovernmental nonprofit hospitals	3,250	3,579	3,670	3,660	3,650	3,600	3,565	3,515	3,518
Beds	368	482	552	595	607	619	629	641	652
Occupancy rate [2]	74.8	77.3	78.2	80.2	81.0	80.2	79.1	77.6	78.0
For-profit hospitals	1,470	982	980	871	849	858	845	845	883
Beds	55	46	54	55	55	59	61	65	73
Occupancy rate [2]	63.6	67.6	69.1	73.8	75.5	72.4	71.3	68.9	68.6

[1] Based on Bureau of the Census estimated resident population as of July 1.
[2] Ratio of average daily census to 100 beds. [3] State hospitals included with "Local."

Source: American Hospital Association, Chicago, Ill., *Hospitals*, Guide Issue, annual, beginning 1972, *Hospital Statistics*, annual. (Copyright.)

available, a patient cannot be admitted for treatment. Less obvious, but equally important according to many, is that when *too many* beds are available in a hospital, certain things happen: the hospital begins to lose money and the costs for other patients increase, doctors begin to urge elective surgery to pump up business, and some necessary hospitals close their doors. Because the system of hospital utilization is a critical aspect of our health care system, debaters must examine the relevant information carefully.

Statistics gathered for the book *Health: United States 1975* and published by DHEW indicate the major types of service anticipated in hospitals reporting (see Table 22). Special attention should be paid to the categories included in Table 22, as well as to the trends for inclusion of the specific service mentioned. The specific sources for the compilation are each useful to the debater interested in an intensive study of any of these specific hospital services.

One of the most interesting trends observable in Table 22 is that of number of hospitals which provide open-heart surgery facilities. A few debaters may wish to question whether there is any necessity for so many hospitals providing this care, given the relatively small number of surgeons who provide this service. On the opposite pole, the fact that only 3,721 of the 6,070 hospitals reporting maintained intensive care units might tend to support the need for the broadening of the services maintained by hospitals.

Nursing and related-care homes play an important role in the health care service of the United States. The *Statistical Abstract* noted that in 1973-74 there were about 16,100 such facilities with over 1.1 million beds operating in the United States. These facilities accommodated something over one million residents in the same year. About 114,000 of these residents were under 65 years of age; the rest were over 65. These older residents represented 89.4% of the nursing home population. These figures exclude those homes providing personal care, domiciliary care, or room and board only (an additional 5,000 homes in 1973-74).[119]

Payments for nursing homes came almost equally from Medicaid (49.9%) and public assistance programs (46%). The remaining 4.1% was provided by Medicare, according to the chart provided by the U.S. National Center for Health Statistics, Vital and Health Statistics (Series 12, Nos. 5, 9, 21, and 23), published in the *Statistical Abstract*. One would presume that little personal payment is made to this particular kind of nursing home.[120]

Mental care facilities, identified in Tables 9, 10, and 11, represent another aspect of the health care facilities of the United States. As will be noted later, there are some serious problems relating to the delivery system of mental care in the nation.

Treatment

"Treatment," a broad and encompassing word, is employed here to describe use of drugs, rather than to refer to the specific choice of service to be provided to citizens by health professionals. Omitted, but clearly

Table 22. Number of Hospitals Reporting Services: 1962-1973.[118]

Hospital services	Number of hospitals reporting							
	All hospitals					Medical & surgical[1]		
	1962	1970	1971	1972	1973	1970	1971	1973
Total	6,814	6,993	6,964	6,622	6,960	6,053	6,008	6,070
Abortion services	---	---	810	1,033	2,624	---	793	2,591
Blood bank	3,420	3,785	3,862	3,840	3,972	3,655	3,728	3,845
Burn care unit	---	---	122	146	152	---	120	148
Cobalt therapy	---	727	768	784	787	712	752	774
Dental services	2,687	---	---	2,493	2,506	---	---	2,025
Electroencephalography	1,372	2,302	2,379	2,500	2,619	1,978	2,040	2,297
Emergency department	5,725	---	5,418	5,023	5,225	---	5,368	5,189
Extended care unit	---	974	812	833	834	732	645	715
Family planning service	---	---	547	529	542	---	522	522
Genetic counseling	---	---	136	194	210	---	124	195
Histopathology laboratory	---	3,066	2,922	2,985	3,124	2,878	2,745	2,954
Home care program	510	593	440	422	434	476	391	404
Hospital auxiliary	4,147	4,636	4,336	4,236	4,321	4,227	4,052	4,080
Inhalation therapy department	---	3,523	3,765	3,871	4,312	3,378	3,622	4,155
Intensive cardiac care unit	---	2,529	2,876	2,062	2,081	2,509	2,853	2,064
Intensive care unit	1,313	3,068	3,275	3,518	3,838	2,919	3,143	3,721
Occupational therapy department	1,471	1,600	1,666	1,706	1,719	940	1,001	1,097
Open-heart surgery facilities	---	442	460	497	512	436	455	508

Table 22. Continued

Hospital services	Number of hospitals reporting							
	All hospitals					Medical & surgical[1]		
	1962	1970	1971	1972	1973	1970	1971	1973
Organ bank	---	192	169	154	164	174	159	158
Organized outpatient department	---	2,721	2,216	2,038	1,970	2,264	1,940	1,759
Pharmacy	3,668	5,744	5,768	5,644	5,891	5,062	5,053	5,239
Physical therapy department	3,187	4,176	4,344	4,430	4,647	3,743	3,899	4,214
Podiatrist services	---	---	---	1,023	1,118	---	---	846
Postoperative recovery room	3,829	4,770	4,805	4,754	4,972	4,507	4,565	4,764
Premature nursery	3,323	2,471	2,398	2,204	2,222	2,450	2,380	2,205
Psychiatric services	1,208	4,475	4,941	6,487	6,642	3,144	3,783	5,016
Psychiatric foster and/or home care	---	242	236	229	224	70	66	73
Radioisotope facility	1,491	2,175	3,677	3,902	4,263	2,132	3,607	4,180
Radium therapy	973	1,583	1,542	1,511	1,515	1,562	1,518	1,494
Rehabilitation services	929	1,787	1,185	987	973	1,216	839	781
Renal dialysis	---	1,079	1,110	1,184	1,353	1,066	1,097	1,339
Self-care unit	---	541	423	333	303	397	307	240
Social work department	---	2,379	2,765	3,173	3,479	1,678	2,026	2,763
Speech therapist services	---	---	---	1,236	1,350	---	---	1,102
Volunteer services department	---	---	---	2,678	2,785	---	---	2,280
X-ray therapy	2,136	1,997	2,080	1,997	2,001	1,947	2,004	1,926

[1]Data for 1962 and 1972 are not available.

SOURCES: 1962 - Journal of American Hospital Association, August 1, 1963 - Guide Issue, pages 478-481, table 5.
1970 - Health Resources Statistics, NCHS, 1971 issue, page 310, table 186.
1971 - Health Resources Statistics, NCHS, 1972-73 issue, page 370, table 207.
1972 - Health Resources Statistics, NCHS, 1974 issue, page 366, table 207.
1973 - Unpublished data from NCHS Health Statistics Master Facility Census.

important, are the various mechanisms which aid the health professionals in both diagnosis and treatment. For example, the use of x-rays as diagnostic devices has continued to climb within recent years—the potential abuse of just this one device prompted federal legislation relating to the design of the equipment. A second example, eyeglasses, represents an item required by the majority of the American population; yet current law does not provide assistance for the purchase of eyeglasses. The focus included below is intended to provide the debater with insight into this vital treatment area, drugs.

Drugs have become a regular part of most Americans' everyday life; over $9 billion is spent annually on prescription drugs. The drug industry, "besides being one of the biggest industries in the country, is also one of the most profitable. In fact, for all but two years from 1956 through 1971, the drug industry was the most profitable U.S. industry, and in the off years, the second most profitable."[121] The drug industry consists of some seventy firms and is dominated by about twenty of them. These twenty firms account for 90% of all sales and are the industry's profit leaders. Most of these firms have international operations. These industry leaders are able to control and, at times, manipulate the demand for their products.[122] According to a tabulation reported in the *Yale Journal of Biology and Medicine*, Americans spend 20.7% of their health care dollars on drugs and appliances.[123] This estimate suggests the significance of the relationship of drugs to the broader health care system of the nation.

Much of the money spent on drugs in the United States is for people with chronic conditions. "Patients with chronic conditions contribute more to the pharmacists making money than those with non-chronic ailments. Statistically, individuals with non-chronic illnesses get only 1.7 prescriptions per year as opposed to 8.1 prescriptions per year for the chronically ill."[124]

Prescriptions can be quite expensive, especially for the elderly and poor. "Today it's not unusual for people on chemotherapy, using cytoxin or doxorubicin or whatever, to have prescription bills of $120 a month or more. This type of customer is really up against it."[125] And once a patient is out of the hospital, prescription prices are not generally covered under present Medicare, private health insurance, or other prepayment plans for the elderly. Therefore, prescriptions "account for an appreciable proportion of the out-of-pocket health expenditures which elderly patients or their relatives must pay."[126]

Physicians rely upon drug manufacturers for their drug information. Since there is "virtually no clinical, psychiatric-pharmacotherapy training in medical schools, doctors in training 'pick up' the information and they get most of it from the drug companies"[127]—from detailmen, advertisements, and elaborate direct mailings which flood their offices. The drug industry spends at least $5,000 to persuade each doctor to prescribe drugs.[128]

The generous use of psychoactive drugs by physicians has not met the health care needs of the United States. "Far from alleviating the complaint, however, psychoactive drugs tend to obscure the real problems—whether

social or interpersonal—and guarantee that they will continue to fester below the surface until they burst."[129]

As noted earlier, immunization is part of the system of health care. According to *Time* magazine, in 1975 "forty states (plus the District of Columbia) require[d] preschool immunization against polio, 41 against measles, 39 against diphtheria, and 34 against rubella. Nine states [had] no requirements; Arizona, Idaho, Indiana, Iowa, Utah, Vermont, Washington, Wisconsin, and Wyoming."[130] The health care system of the United States does, in a great number of states, include prescribed use of drugs as immunization against disease. The swine flu episode of 1976 further illustrates the commitment to immunization by means of drugs. As Assistant Secretary for Health in the Department of Health, Education, and Welfare, Dr. Theodore Cooper was ultimately responsible for the federal government's crash program against swine flu in 1976.[131] The *Atlantic Monthly* editorialized that "the government has no cogent preventive medicine policy at all and is virtually incapable of dealing rationally with such matters of scientific controversy."[132]

"During the early 1950s, some 38,000 Americans were victimized by polio each year. . . . There were only seven cases of polio in 1974."[133] Despite some distressing signs of drug company reluctance to continue mass production of vaccines, the record of the industry is not all one of searching for profits. Real problems, created by potential liability suits as well as cash flow, influence drug companies in their judgments of what product to produce.

The final structure to be discussed within this section, the Health Maintenance Organization (HMO) concept, represents a potential solution to some of the problems facing the health care system of the United States. Health Maintenance Organizations are "comprehensive, prepaid systems of health care with emphasis on the prevention and early detection of disease, "[134] or "group medical practices that contract to provide a range of services in return for a fee paid in advance."[135] Since the organization receives only a fixed amount from each member, HMOs usually provide health care in a more efficient, less expensive manner than other kinds of medical programs and are more effective in keeping people healthy.

The proponents of the HMO concept claim that not only does the HMO have a profit incentive, but, since future costs are influenced by current utilization rates, so do members. Further, since members' medical costs are prepaid, they tend to go to the doctor before a problem becomes serious. This would result in less member time in hospitals, if true.[136]

The breadth of care expected within the HMO concept contributes to the very high initial establishment cost. The Health Maintenance Organization Act of 1973, which has operated pilot programs, is intended to stimulate growth of HMOs. The Act requires companies with more than 25 employees to offer workers a chance to join "an 'approved' HMO—if there is one in the area—as an alternative to any medical program the company already has."[137] Despite this incentive, by mid-1976 "only twelve of more than 200 groups now in existence [had] qualified for federal

certification; five of these [were] in serious trouble."[138] One reason for the apparent problem is that an approved HMO must accept all those who apply for membership, regardless of medical condition and, in addition, is required to provide dental care for children under twelve years of age and extended mental health coverage.[139]

The largest of the prepaid group insurance programs, Kaiser's Permanente Health Plan, provides documentation for the effectiveness of such programs.[140] An interesting study relating to use of HMOs as a delivery system for the poor is in *The Health Gap: Medical Services and the Poor*.[141]

Leon Warshaw provided clarification of the concept of HMOs in 1975: "The term 'HMO' has come to have almost as many meanings as the number of people who use it. To many, it is a synonym for the closed-panel prepaid group practice program which . . . limits its service to its enrolled members."[142] The HMO enrollment went from 5.75 million members in January 1974 to 6.46 million members in January 1975, an increase of 12%.[143] According to DHEW estimates in 1975, there were 173 prepaid health care organizations across the country.[144] Not all of the organizations employed the same system. One rural HMO, in North Quabbin. "concentrated on bringing together existing medical facilities into a coordinated-care system. As a result, capital expenditures have been kept down."[145]

The organizations have state support. By the middle of 1975, twenty-five states had enacted specific HMO enabling legislation. Additionally, fifteen states had contracted with HMOs to provide health care to over 340,000 Medicaid recipients by May of 1975.[146]

The federal government has operated a demonstration project for five years relating to HMOs. "Outlays for the health maintenance organization (HMO) program in 1977 will total $20 million. This demonstration program supports HMOs. . . . New HMO funding commitments under this 5-year federal demonstration effort will be completed by 1977."[147]

In the absence of a national program of comprehensive health insurance, people in the United States have used group health insurance, such as that provided by Blue Cross and Blue Shield since the 1930s. Many of these programs have recently boosted benefits on major medical plans. "Past practice has been for such plans to contain a lifetime limit on the total amount of benefits a person could receive. According to one study, only 14% of those covered by insurance group major medical plans in 1966 had maximum benefits of $20,000 or more. But to take care of rare catastrophic illnesses, more companies are raising maximum benefits available in group major medical plans to $1 million or even an unlimited amount."[148]

Summary

Within this section the "system" of health care in the United States has been introduced. Health care costs, government and health care, ill health in the United States, the health professionals, and facilities and treatment have been discussed. The data incorporated into this section should be of use to the debater as he or she begins to prepare for the 1977 debate topic.

Problems of the Health Care System

As must be clear from a reading of the prior sections, our health care system is multidimensional. In fact, calling our delivery of care a "system" is, at best, providing us with an umbrella term which covers diverse elements. The debate cases of 1977 will, in fact, respond to specific problems with specific solutions. In this analysis, broad generalizations, occasionally developed with supports, provide some insight into areas which may be developed into cases.

The evaluation of a system is almost totally dependent upon the perspective of the viewer. If a child has the measles and is cared for by the health care system, one view would commend the present system. Another view would note that proper immunization policies would have prevented the child from having a case of measles. Aid to Dependent Children, available through Medicaid, is rife with tedious reporting mechanisms and, as such, might be an example of a failure within the health care system if the child with measles were denied the immunization as a consequence of those reporting procedures. Further, children born of mothers who contracted rubella while pregnant frequently suffer from serious impairments and, consequently, suffer from current policies relating to immunization. The perspective of the viewer, in the four situations described above relating to measles and our health delivery system, determines the direction of the "problem" to be discussed.

The same five categories discussed in the previous section relating to the system of our health care will serve as categories for discussion of problems within that system: (1) health care costs, (2) government and health care, (3) ill health, (4) health professionals, and (5) facilities and treatment.

One final reminder is included for beginning debaters: the word "harm" is used in most debate circles in two different ways; a harm may be the *existence* of an undesirable condition or the *absence* of a beneficial condition. That definition will be employed throughout this section.

Health Care Costs

"The effects of inflationary pressures and of fluctuations in employment levels in the general economy have been felt in the health care sector. We can expect these and other forces for change to continue to operate in the future."[119] Statements such as this are general indicators of the prospects for continued cost increases within the area of medical care in the future. The implications of these increases apply to all citizens but those at the top of the economic ladder in the United States.

People like Joseph A. Califano, Jr., President Carter's Secretary of Health, Education, and Welfare, are aware of the dangers of additional

government action in the health care field. In a press conference held on February 19, 1977, speaking about a price control plan being discussed with the heads of Blue Cross, the American Hospital Association, and the American Medical Association, Califano warned hospital administrators not to "rush to increase charges simply because we are coming forth with a proposal like this."[150]

The general viewpoint is that "rising hospital charges are a major factor in the runaway inflation that has plagued the $140 billion health care industry, and the administration believes those costs must be brought under control before its promised National Health Insurance program can be formulated and implemented."[151]

Many people are having to tighten up their economic belts in order to deal with the continuing rise in the cost of medical care. With a cost of $547 per capita,[152] which represents one month's salary of the average worker in the United States,[153] it is easy to understand why many people are turning to third-party payments in order to find relief. Nine out of ten Americans are covered by some form of third-party payment; by insurance companies, Medicare, or Medicaid.[154] Table 23 provides the data from which the impact of the medical care component upon the general economy can be observed. Table 24 shows the consumer price indexes from 1940-76, an important gauge of this country's economic outlook.

Debaters must be concerned with "impact." Clearly, there are impacts upon individuals and groups in the United States which are the consequence of the soaring cost of health care. But identifying these harms with "body counts," "death and suffering," or "economic deprivations" is the primary task for a debater who wishes to argue from the premise that health costs are high.

As a theoretical sidelight, the reader is warned that *neither* of the usual answers to this impasse is recommended by this writer. The first answer is to look for a case which talks about a very narrow problem (the number of angels which could exist on the head of a pin was a favorite topic at the turn of the century). The second answer is to talk in banal generalities (costliness is next to mortal sin, according to the generalist, and therefore requires no impact).

If the impasse is to be avoided, and if the debater wishes to consider the most obvious impact of the medical delivery system in 1977—its cost—then where should he or she turn for more useful arguments? This writer believes that they are to be found in two general directions: citizens' pain and suffering from deficient elements of the delivery system identified in later segments of this section *and* general economic imbalance directly resulting from the inflationary effects of the health care system.

To exemplify the first of these two directions requires little more than citing the link which exists between the cost of treatment, the tendency of working men and women to postpone care when the cost is not prepaid, and the later pain and suffering they experience when the inevitable illness occurs. Both pain and suffering and economic deprivation from work-days lost exist within this simple model of the impact of our health care system.

Table 23. Medical Care Component of the Consumer Price Index, 1940-76.[155]

[1967=100; yearly data are annual averages]

Period	Total	Medical care services								Drugs and prescriptions	
			Hospital service charges				Professional services				
		Total	Total[1]	Semi-private room[2]	Operating-room charges	X-ray, diagnostic series, upper G.I.	Physicians' fees	Dentists' fees	Examination, prescription, and dispensing of eyeglasses	Routine laboratory tests	Prescriptions	Over-the-counter items
1940	36.8	32.5	.....	13.7	.....	.....	39.6	42.0	58.1	.....	66.2	.....
1945	42.1	37.9	.....	17.6	.....	.....	46.0	49.6	63.9	.....	71.5	.....
1950	53.7	46.2	.....	30.3	.....	.....	55.2	63.9	73.5	.....	92.6	.....
1955	64.8	60.4	.....	42.3	.....	.....	65.4	73.0	77.0	.....	101.6	.....
1960	79.1	74.9	.....	57.3	.....	.....	77.0	82.1	85.1	.....	115.3	.....
1961	81.4	77.7	.....	61.1	.....	.....	79.0	82.5	87.8	.....	111.5	.....
1962	83.5	80.2	.....	65.3	.....	.....	81.3	84.7	89.2	.....	107.1	.....
1963	85.6	82.6	.....	68.6	77.9	89.0	83.1	87.1	89.7	91.6	104.5	96.7
1964	87.3	84.6	.....	71.9	79.4	89.7	85.2	89.4	90.9	93.0	103.1	97.3
1965	89.5	87.3	.....	75.9	82.9	90.9	88.3	92.2	92.8	94.8	102.0	98.0
1966	93.4	92.0	.....	83.5	88.6	94.1	93.4	95.2	95.3	96.8	101.8	99.0
1967	100.0	100.0	.....	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
1968	106.1	107.3	.....	113.6	111.5	104.3	105.6	105.5	103.2	103.5	98.3	102.5
1969	113.4	116.0	.....	126.8	126.7	109.3	112.9	112.9	107.6	107.5	99.6	103.2
1970	120.6	124.2	.....	145.4	142.4	116.3	121.4	119.4	113.5	111.4	101.2	106.2
1971	128.4	133.3	.....	163.1	156.1	124.9	129.8	127.0	120.3	116.1	101.3	110.3
1972	132.5	138.2	.....	173.9	168.6	129.1	133.8	132.3	124.9	120.4	100.9	111.3
1973	137.7	144.3	105.6	182.1	179.1	131.8	138.2	136.4	129.5	122.8	100.5	112.4
1974	150.5	159.1	115.1	201.5	201.3	140.6	150.9	146.8	138.6	135.4	102.9	117.6
1975	168.6	179.1	132.3	236.1	239.4	156.2	169.4	161.9	149.6	151.4	109.3	130.1
1975												
September	172.2	183.2	135.4	243.2	244.2	159.0	172.9	164.1	151.6	153.8	110.5	132.0
October	173.5	184.6	136.7	245.4	246.6	160.6	174.1	165.1	152.5	153.5	110.9	132.5
November	173.3	184.2	137.6	247.1	249.4	161.6	176.1	165.8	152.9	153.7	111.3	133.5
December	174.7	185.9	138.9	249.1	251.8	163.5	178.3	166.5	153.5	153.8	111.9	134.0
1976												
January	176.6	188.0	142.0	254.8	258.3	167.0	179.5	167.2	154.8	154.3	112.4	134.7
February	178.8	190.4	144.1	259.2	263.2	168.5	181.9	168.2	156.0	154.9	113.1	135.4
March	180.6	192.5	145.4	261.5	265.9	169.8	184.3	169.4	156.7	156.0	113.7	136.1
April	181.6	193.5	146.2	262.5	268.1	171.6	185.6	169.8	157.3	158.1	114.3	137.2
May	182.6	194.6	146.7	263.2	269.4	171.5	186.8	170.6	158.0	160.5	114.9	138.2
June	183.7	195.8	147.1	265.1	270.5	173.3	188.3	171.6	158.7	159.3	115.2	138.9
July	185.5	197.9	149.7	270.8	277.4	175.9	189.4	172.0	159.5	162.0	115.7	139.2
August	186.8	199.4	151.0	273.8	280.5	178.5	190.6	173.5	159.8	163.4	116.4	139.9
September	187.9	200.6	151.6	275.2	281.8	179.1	192.2	174.5	160.5	164.0	116.4	140.6

[1] January 1972=100. Consists of charges for semiprivate room; operating room; X-ray, diagnostic series, upper G.I.; and the following ancillary services: physical therapy, oxygen, intravenous solution, electrocardiogram, antibiotic, tranquilizer, and laboratory tests.

[2] Includes charges to adult inpatients paying full rates for room and board, routine nursing care, and minor medical and surgical supplies.

Source: Department of Labor, Bureau of Labor Statistics.

Table 24. Consumer Price Indexes, 1940-76.[156]

[1967=100; yearly data are annual averages]

Period	All items	All items less medical care	Medical care	Food	Apparel and upkeep	Housing	Transportation	Personal care	Reading and recreation	Other goods and services	All services
1940	42.0	.....	36.8	35.2	42.8	52.4	42.7	40.2	46.1	48.3	43.6
1945	53.9	.....	42.1	50.7	61.5	59.1	47.8	55.1	62.4	56.9	48.7
1950	72.1	.....	53.7	74.5	79.0	72.8	68.2	68.3	74.4	69.9	58.9
1955	80.2	.....	64.8	81.6	84.1	82.3	77.4	77.9	76.7	79.8	70.5
1960	88.7	89.4	79.1	88.0	89.6	90.2	89.6	90.1	87.3	87.8	83.8
1961	89.6	90.3	81.4	89.1	90.4	90.9	90.6	90.6	89.3	88.5	85.2
1962	90.6	91.2	83.5	89.9	90.9	91.7	92.5	92.2	91.3	89.1	86.2
1963	91.7	92.3	85.6	91.2	91.9	92.7	93.0	93.4	92.8	90.6	88.5
1964	92.9	93.5	87.3	92.4	92.7	93.8	94.3	94.5	95.0	92.0	90.2
1965	94.5	94.9	89.5	94.4	93.7	94.9	95.9	95.2	95.9	94.2	92.2
1966	97.2	97.7	93.4	99.1	96.1	97.2	97.2	97.1	97.5	97.2	95.8
1967	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
1968	104.2	104.1	106.1	103.6	105.4	104.2	103.2	104.2	104.7	104.6	105.2
1969	109.8	109.7	113.4	108.9	111.5	110.8	107.2	109.3	108.7	109.1	112.5
1970	116.3	116.1	120.6	114.9	116.1	118.9	112.7	113.2	113.4	116.0	121.6
1971	121.3	120.9	128.4	118.4	119.8	124.3	118.6	116.8	119.3	120.9	128.4
1972	125.3	124.9	132.5	123.5	122.3	129.2	119.9	119.8	122.8	125.5	133.3
1973	133.1	132.9	137.7	141 4	126.8	135.0	123.8	125.2	125.9	129.0	139.1
1974	147.7	147.7	150.5	161.7	136.2	150.6	137.7	137.3	133.8	137.2	152.0
1975	161.2	160.9	168.6	175.4	142.3	166.8	150.6	150.7	144.4	147.4	166.6
1975											
September	163.6	163.2	172.2	177.8	143.5	168.9	155.4	152.1	146.0	148.0	169.1
October	164.6	164.1	173.5	179.0	144.6	169.8	156.1	152.9	146.6	148.5	170.1
November	165.6	165.2	173.3	179.8	145.5	171.3	157.4	153.6	147.0	148.9	172.0
December	166.3	165.8	174.7	180.7	145.2	172.2	157.6	154.6	147.5	149.8	173.1
1976											
January	166.7	166.2	176.6	180.8	143.3	173.2	158.1	155.7	148.2	150.5	174.9
February	167.1	166.5	178.8	180.0	144.0	173.8	158.5	157.0	148.5	151.3	176.1
March	167.5	166.8	180.6	178.7	145.0	174.5	159.8	157.4	149.0	151.8	177.2
April	168.2	167.4	181.6	179.2	145.7	174.9	161.3	158.3	149.5	152.5	177.7
May	169.2	168.4	182.6	179.9	146.8	175.6	163.5	158.9	150.3	152.9	178.4
June	170.1	169.4	183.7	180.9	146.9	176.5	165.9	159.8	150.9	153.2	179.5
July	171.1	170.3	185.5	182.1	146.5	177.5	167.6	160.5	151.2	153.6	180.7
August	171.9	171.1	186.8	182.4	148.1	178.4	168.5	161.6	151.4	153.8	181.8
September	172.6	171.7	187.9	181.6	150.2	179.5	169.5	162.8	152.8	153.9	183.2

Source: Department of Labor, Bureau of Labor Statistics.

Extensions exist within the increased likelihood of severe illness when treatment is delayed. The problem which affirmative teams developing this approach must face is establishing the links between (1) cost and not seeking treatment, (2) not seeking treatment and eventual illness, and (3) eventual illness and an augmented problem (pain, suffering, economic deprivation). In addition, proving the breadth and intensity (significance) of this condition becomes a proof problem for the debater.

Exemplifying the second direction is simpler. If costs in health care are out of proportion to the general economic trends of the United States, then they create an inflationary impact upon the total economy. The extent of the impact, a problem of significance, requires careful research. So, too, does the basic notion that inflation is undesirable in the United States. But once these two problems of case development are resolved, the approach might well be successful on this year's debate proposition.

At this point, some might wonder how a case on the health care system topic could present as an advantage "improving the economic condition of the United States." Two answers are provided here: (1) the advantage responds to the statement of the *problem area* by indicating that the modified health care system is best for the United States because it saves the economy and (2) the advantage responds to any of the specific *propositions* in a similar way.

Many teams might wish to consider a multiple-advantage case which addressed itself to both economic benefits and reduction in pain and suffering. Such an approach, while not specifically encouraged here, would represent one way to escape the impasse posed above regarding excessive narrowness or banal generality.

The specific case areas which emerge from the spiraling costs of health care would include a number of specific population groups. Prominent among these groups would be the elderly, the poor, the permanently disabled, the geographically isolated, and those suffering from catastrophic illnesses. Also available as potential problem categories would be those in mental hospitals, those within the jurisdiction of Veterans Administration care, and victims of welfare frauds. Each of these areas represents viable case prospects. In most instances, the various levels of government have sought solutions. Some of the programs have been more successful than others. For example, there is good evidence, cited earlier, to indicate that most of the medical bills of the elderly are being paid by the federal government's Medicare program. Evidence is also given which indicates that the states work to provide proper facilities for mental care.

Fairly sophisticated debaters might wish to develop cases related to costs which are based upon the improvement in the *system*. Such cases, for example, might argue that the programs, while providing health care, are accomplishing the goals in less desirable ways than whatever system they propose. The advantages which such teams would argue as sufficient to change the present system are difficult to quantify. For example, a national insurance scheme proposed by an affirmative team might be claimed as a superior *system* of health care delivery. How many more people would get

care in such a program? How much better would the care be in such a program? These questions, premised upon the notion that *numbers can tell everything about a proposal,* are important but are not the only questions. For there may well be virtue in systematic approaches which escape quantification. The task of illustrating these virtues, of course, remains with affirmative debaters who urge this approach.

Government and Health Care

As noted previously, our government actions are manifold. Medicaid, Medicare, the Hill-Burton Act, the Veterans Administration, the various Institutes of Health, the divisions of DHEW such as the training of health professionals—all these federal actions and programs reflect upon the question of how our government is tending to the health care business. Add to these the many state and local actions, as evidenced by school immunization laws, and the task of evaluating the problems in government care for our health becomes even more difficult.

Following is a discussion of some of the more obvious deficiencies in the governmental programs. Each of the government programs provides territory for case development.

Medicaid

"The cost of hospitalization rose 186% between 1960 and 1971, while other consumer prices rose 37%. This is generally explained by the flood of cost-plus money from Medicare and Medicaid which eliminates any incentive for physicians, patients, or hospital administrators to control costs."[157] Such conditions provide the point of departure for indictments of the specific government program. Further, the affirmative team which begins from such a base has a ready policy change available with which comparisons might be made.

Hospitals are not the only problem area related to Medicaid programs. Many nursing home operators have been accused of cheating their patients. "Operators have been discovered spending as little as 27 cents per patient per day on food, recycling untouched portions of meals, hiring incompetent personnel at low rates, cutting heat in winter and air conditioning in summer."[158]

State commitment to the Medicaid program has declined in certain areas. "Some have cut the number of services provided by the program, others the number of people they serve. Still others have reduced the fees paid to the physicians, hospitals, and other providers that treat Medicaid patients."[159] The specific impact of declining state commitment to the program might well represent an area which is worthy of affirmative case analysis.

With respect to fraud by ineligible recipients, there may well be some room for argument. "Sen. William Proxmire (D-Wis.) said yesterday the Department of Health, Education, and Welfare will pay more than $600 million in 1975 for illegal Medicaid benefits to poor despite proposed new rules aimed at reducing an ineligibility rate now running at 30 percent."[160]

Other abusive practices exist. "Involved on a scale far more vast than earlier suspected is the wide range of abuses, including such things as bill padding by doctors, kickbacks by medical laboratories, illegal claims by patients and massive swindles in the operation of nursing homes."[161]

A particularly perplexing situation seems to exist in the program: "Several witnesses told the subcommittee that Medicaid would pay to keep them in nursing homes but would not help finance efforts to live and work independently outside such homes."[162] Dr. Chafin, chair of a Texas Medical Services Subcommittee, said, "The system seems designed to keep people in the system. It's easier to go along and stay in it than try to go out on their own.... I'm pretty sure we're throwing too many people in hospitals when they could be treated better under other conditions."[163]

Medicare

Much of the information above applies to the Medicare program as well. Many health care homes are extremely inadequate and poorly run. The aged who live in such homes frequently suffer from irregular serving of meals, have little opportunity for social contact, and are often heavily sedated and even ignored. Because Medicare does not cover nursing home benefits to any substantial degree, many elderly avoid seeking badly needed health care. Routine health examinations and preventative health care are not paid for by Medicare. One clinic official has reported that "a significant portion of people coming to the clinic are in immediate need of medical care. Overall estimates made by our medical staff indicate that approximately 10 to 15 percent of the clinic patients require the immediate attention of a physician and approximately 80 percent of the patient visits to the clinic subsequently result in hospitalization."[164]

Exclusionary clauses provide affirmative teams with the territory of harms which persist despite Medicare. "The custodial care exclusion precludes payment for that type of care, wherever furnished, which is designed essentially to assist the individual in meeting his activities of daily living."[165] Routine physical checkups are excluded. They include "examinations performed without relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury."[166]

The fee payment system of Medicare also influences the general evaluation of the system. As Dr. Sidney M. Wolfe, director of Nader's Health Research Group, noted, "The big differences in allowable charges adds at least $1 billion a year to national health costs. It's pure, unadulterated lack of control."[167] The cost allowed for a blood transfusion varied from $38 in Detroit to $10 in Houston. An electrocardiogram varied in allowed cost from $15 in Chicago to $25 in San Diego.[168] Responding to a complex formula essentially based upon what the physicians in a given area are charged, the fee payment schedule may well contribute to some of our nation's health care cost problems.

Hill-Burton Act

The biggest problem with the hospital construction done under the funding provided by the Hill-Burton Act is that there has been substantial

over-building of rural facilities. Since, in the 25 years the program has been in operation, the population of the United States has shifted markedly into urban centers, some of the urban hospitals are substantially overcrowded.

By reviewing Table 7, debaters can observe the application of Hill-Burton projects, in terms of both the amount paid by the program and community size. Table 8 indicates the percentage of Hill-Burton funds which were distributed between 1948 and 1971 to hospitals within counties in which the median family income was less than $7,000. The 19.2% above the figure of total projects received 31.4% of the dollars. Although costs for construction within the higher income counties might well account for this distinction, debaters might want to pursue the matter further.

The various amendments to the aid program have facilitated better hospital and care facility construction. The questions which must be posed by debaters in this area are related to efficacy of the system.

Veterans Administration Health Care

Staffing and bed space seem to be the biggest problems which currently affect the Veterans Administration hospital system. Affirmative teams which choose to develop arguments relating to this system will be obliged to focus upon the distinction between care from this source and care from other sources. The existence of the program, on the other hand, is thought by some to be an anomaly. These critics point out that the necessity for operating more hospitals than any other single hospital system in the nation escapes logic. The duplication of services, the direct tax costs to the general public, and the prospect of substantial tax saving if the system were integrated into the regular health delivery system of the nation are appealing arguments for a systematic treatment of the health care needs of Americans.

Other Government Programs

The Health Manpower Training Act, the NIH, and many more measures have been enacted over the years by Congress. These various measures are intended to provide needed services to the public. Health care may be big business, but it is also the recipient of much congressional activity. The negative teams which consider these various acts as mechanisms by which we can resolve various problems will find sympathetic audience from the more traditional inherency judges this year. But one warning is necessary. The value of a mechanism is measured by the likelihood of its use. If the negative attempts to expand a whole series of mechanisms, some judges would expect them to (1) identify the propensity of the expanded mechanism to resolve the problem, (2) defend the premise that their modification does not represent a counterplan (and the changed duties that would imply), and (3) clearly avoid contradictions with the second negative disadvantages.

One example might clarify the theoretical observation made above. The present system can provide funds for the training of paraprofessionals, people who could provide the basic care for hospital patients with

affirmative arguments of doctor shortages by proposing a massive infusion of funds for training nurses' aides, would that infusion represent a change in the system? Many would believe that it would. Further, unless the negative made a firm commitment to the expansion, including implementation details, shouldn't the judge compare the certainty of the affirmative proposal against the riskiness of the "potential" negative repair? Again, many would make that judgment.

Ill Health

Government Research

Despite a recent decline in the death rate from coronary heart disease, cardiovascular disease continues to be the number one killer in the United States. Arteriosclerosis and hypertension account for over one million deaths annually. An estimated 30 million Americans have diseases of the heart and blood vessels, resulting in a large burden of acute and chronic illness and disability. Heart and blood vessel diseases cost the economy more than $40 billion per year in wages, lost productivity, and expenses for medical care.

Diseases of the lung constitute a major national health problem. An estimated 10 million Americans, both young and old, are currently affected by these diseases, with an annual estimated cost to the nation of over $17 billion. In the newborn, the most common cause of death is neonatal respiratory distress syndrome, and this syndrome is implicated in the development of adult respiratory diseases, as well. Fibrotic and immunologic lung diseases are a major cause of lung problems in the young adult and may cause chronic obstructive pulmonary disease. Of the adult respiratory diseases, emphysema and chronic bronchitis represent a particularly pressing health problem, since the death rate and prevalence of these conditions have increased at an alarming rate over the past fifteen years. As a disabling disease, emphysema is the third leading cause of worker retirement on social security disability payments.

Bleeding and clotting disorders underlie or are a major contributor to many disease processes and, as a consequence, are a major cause of death and disability in the United States. No valid estimate of their adverse economic impact can be realistically made, since disorders of the blood affect not only the blood itself but all of the organs and tissues through which the blood flows. Similarly, when estimating the economic consequences of an inadequate blood resource system, quantitative figures are difficult to determine, since the supply and management of blood and blood products underlie much routine and emergency medical practice. A small but significant segment of the population has sickle cell anemia or other hemolytic diseases, and the suffering and economic impact of these is also serious.[169]

The combined problems of inflation and recession and the economic difficulties which confront us have created great pressure for the reduction of federal expenditures on biomedical research. In a free enterprise system,

basic biomedical research cannot be carried forward on the scale that is required without federal support. Profit incentives are not there to support adequate basic research, and philanthropic institutions must have government help in order to stimulate their activities and to sustain them at the level which the public interest requires. It is also absolutely essential to our success in biomedical research that a portion of our brightest young people are brought into research programs, and fellowships and training grants have proved to be the most effective and most economical ways of doing that.

The cancer program is a vast undertaking which will require long-term support and great patience. Much has been accomplished in recent years. "There is absolutely no question that cigarettes are carcinogenic and that the epidemic increase in primary lung cancer is due to cigarette smoking."[170] It is reasonably certain "that some portion of the bladder, esophageal, pancreatic, and head and neck cancers are also due to smoking. Therefore, it is clear that a very large portion of the environmentally induced cancers are associated with cigarette smoking."[171] However, increased funding is essential in coming years, if the work is to progress. "We must pursue the identification of the substances that cause the disease, and determine how they work, for that is a part of the knowledge we must have in order to make progress against this disease."[172]

Neither the cancer program nor biomedical research in general can thrive if the budget for basic research continues to suffer funding cutbacks. Debaters interested in developing cases based upon the urgency of continued basic research are encouraged to review the structure of the NIH, included in Table 12.

Mental Health

"The economic cost of alcohol abuse in the United States has been estimated at $15 billion per year," says a 1975 Task Force report.[173] That alcoholism is a mental health problem is fairly obvious. But this is merely one of the generally undeveloped areas of mental health within the general approach taken by our government to this broad national problem. "The National Institute on Alcohol Abuse and Alcoholism's (NIAAA) First Special Report to Congress on Alcohol and Health, presented in 1971, estimated that nine million persons, including nearly 10% of the nation's workforce, were alcoholics or abusers of alcohol."[174]

Few welfare services exist for mental health problems of the poor. "Individuals with mental health problems very often have other kinds of problems as well. Financial, housing, employment and physical difficulties, to name a few, complicate and intensify the need for direct and effective assistance along many fronts."[175] One study indicated that multiple inadequacies which were affecting the judgment of welfare recipients seeking medical care went untreated.[176]

The National Institute of Mental Health estimated that each year between 1 and 3 million Americans suffer depressions severe enough to keep them from performing their regular activities and to compel them to

seek medical help. Perhaps 10 to 15 million others have less severe depressions that interfere to some extent with the performance of normal activities.[177] Clearly, the problem of mental health is massive in its proportions. The questions which face affirmative teams relate to the intensity of the problem and the mechanisms by which current attempts are made to control the problem.

Health Professionals

"Census tracts with lowest supply of physicians, both General Practioners and specialists, also had a population which had lower income, education and occupation levels. The tendency to practice in upper class intra-urban census tracts is more pronounced for specialists than for General Practitioners, although holding true for both."[178] The obvious condition—that physicians would gravitate to the places where they could earn more money—creates special problems for citizens in the United States. As noted earlier, funds have been provided to build facilities in rural areas, and the bed-per-capita ratio is different for remote areas than for urban centers. Yet funds for getting physicians to settle in these areas are severely limited. Affirmative teams which develop data relating to these conditions may well have meaningful cases.

"In 1971 specialists comprised approximately 81% of all active non-federal physicians. Specialists comprised the bulk of the physician population and 88% of the specialists practiced in SMBAs. It is not surprising then that 80% of all active non-federal physicians practice in SMBAs where only 72% of the resident population lived."[179] Shortages of many of the various health professionals can be noted. Examination of the data available from the NCHS is a point of departure for information on nurses, clinicians, and the many other health professionals. Table 20 should aid students interested in this subject.

A recent article in *Time* magazine points toward another problem: the quality of care in our hospitals. Reporting on a survey in *Nursing 77*, a professional journal, *Time* noted that "fully 38% of the nurses said they would not, if they had a choice, be treated at their own hospitals. Wrote one: 'All I have to say is. Dear God, may I never have to be a patient.'"[180]

Malpractice

The health professional, primarily the physician, faces another problem: malpractice suits. Unfortunately, according to an article in *Scientific American*, "it is generally the 'good' doctor who is sued; the less adequate practitioner, who is likely to have a stable practice in a small community, will escape lawsuits regardless of his mistakes."[181] The reason for this difference is that "the best physicians are likely to be in charge of the most difficult cases and so may be the target of a number of claims."[182]

Many people claim significant harms have resulted from the climate of fear which has developed among some doctors. One, writing to the *New England Journal of Medicine*, noted that "surgeons are writing up operative procedures to fit the textbook rather than an accurate description

of what was actually seen and done, since the hospital record can be subpoenaed for attorney's inspection at any time. The quality of medical care is certain to deteriorate as long as the present climate of malpractice suits persists."[183]

According to the *Journal of American Insurance*, one effect of the atmosphere is an increasing cost for the customer: "Meanwhile there is another critical cost factor. It is the move by the doctor to order more tests, x-rays and other treatment than necessary to protect himself from litigation. This defensive medicine cost now may run as high as $10 billion annually. Like all costs, it is the patient who ultimately pays."[184]

Is there any reason for this climate? "Court data in Cook County, Illinois, show that 522 malpractice suits were filed in 1973 and 818 in 1974. In January-February 1975 alone 158 suits were filed, compared to 116 suits in the first two months in 1974. Also significant: the average verdict per successful plaintiff was $116,799 for 1974-75 midterm six months, compared to $40,019 for 1973-74 full-term twelve months."[185]

Other Health Professional Problems

Debaters can develop an area of significance from a number of different perspectives within this category. The paraprofessional who would replace skilled nurses in hospitals has distinct advantages—in cutting costs, in developing rapport with the patient which the busier nurse could not do, and in extending the service the nurse can give. The benefits which flow from programs for training additional professionals are substantial. The current shortage can serve as a rationale for change in these directions. In most instances, the shortages will be in the less-populated areas; therefore, some additional attention must be paid to the peculiar benefits available from a federal, rather than a local, solution.

Facilities and Treatment

Much of the problem area noted above relating to health care costs is relevant to this specific section, as well. That the hospital location, equipment, staffing, and cost all interact with the prospect for good health would appear obvious. The absence of any single element in this delivery system creates the prospect for an affirmative case. By the same token, if any specific category is being deprived, on a regular basis, of specific care which would normally occur in the hospital setting, then the affirmative debater is "in good territory."

The occupancy rate in facilities was high in 1973. When 77.5% of space is utilized, the hospitals are operating efficiently. The principal problem which a debater may wish to consider is whether that rate is the norm or is based upon almost 100% occupancy in the metropolitan centers and very low levels of occupancy in the rural centers which have been financed by the Hill-Burton construction of the past twenty years. Careful consideration of the details available in Tables 6, 7, 8, 21, and 22 might well assist the debater in his or her preliminary analysis. The tables relating to mental health further illustrate the potential problem.

The general inattention to preventative treatment may well be a consequence of the delivery system which provides fee-for-service care rather than a "health maintenance organization" approach. Exercise therapy is simply not a part of the present systematic treatment for citizens. Within a different frame of reference, exercise, vitamins, and other viable mechanisms of maintaining health rather than restoring it would be appropriate. Table 14 indicates that substantial portions of our population, at all ages after seventeen, wear lenses. Many people, however, do not get appropriate prescriptions for lenses. The incorporation of this problem in a debate could equal effective argumentation. As Thomas Weges noted in hearings held by the Subcommittee on the Health of the Elderly on June 25, 1974, "Hypertension is one of the most significant public health problems in this country today, not only in just the geriatric age group . . . waiting until target organ damage has occurred, such as a stroke or heart attack, is simply disastrous. The early detection and treatment of hypertension significantly reduces the mortality and the morbidity from vascular disease."[186] Such opinion is expressed in much of the literature on this topic. From these opinions and statistics on the number one killer in the United States comes the prospect for a very significant affirmative case.

Treatment, whether preventative or curative, of individuals in the United States involves drug companies. For example, one writer, commenting upon overuse of vitamins, noted: "Megavitamin use eventually can create an unnatural adaptation, a drug dependence; cessation of the regimen then results in a withdrawal situation—a self-induced deficiency. We know that this can happen with massive doses of vitamine C. We strongly suspect it can occur with the B-complex vitamins also."[187]

Cases of vitamin deficiencies, especially deficiencies of C, D, and folic acid,[188] still occur in various sections of the United States. These deficiencies could stem from numerous sources, among them malnutrition, interaction of vitamins with certain medicines, climate, and the dietary programs of certain hospitals and nursing homes.

Inoculations might be another aspect of the problems within the world of drug companies. As was noted in the *Atlantic Monthly*, "A clear-cut policy in these areas may be urgently in order because, the pros and cons of the swine flu controversy notwithstanding, the American performance on vaccinations against dangerous disease has slipped badly. Measles are on the increase, supplies of safe polio vaccine have run low in many cities, and it is estimated that as many as 40 percent of all children now start school without the proper immunizations."[189] The Committee on Interstate and Foreign Commerce favorably reported a bill (H.R. 12678) to amend the Public Health Service Act, which dealt with disease prevention and control programs.[190] Further information is available in statements made during the *Senate Hearings before the Committee on Appropriations for Fiscal Year 1977, Part 8*, where allergies and infectious diseases are discussed in some detail.[191]

The impact of excessive sales tactics by drug company "detailmen" is

chronicled in many sources. Adverse drug reactions represent an area which might well be argued by affirmative teams. Essentially, the harm develops as a consequence of the pressures placed upon the doctor by the drug company detailmen to use their product. Lacking sufficient data, the doctors overprescribe, use a pill less effective than others, or simply misprescribe; they are aided and abetted by the detailmen, by advertisements which flood their offices, and by the general public's commitment to the "Pain-Pill-Pleasure" model of society.

"Physically, use of [psychotropic, or hallucinogenic,] drugs may also pose a serious health threat. Besides the typical and sometimes severe side effects, such as nausea, headaches, nightmares, and impaired neuromuscular coordination, many of the psychotropics pose graver dangers. Doctors in mental hospitals have discovered only in the last few years that the trembling muscles and slurred speech of a third of their mental hospital patients do not come from their affliction but from the cure—chronic use of psychotropic medicine."[192]

Private Insurance/Group Insurance Programs

Substantial portions of our population are not currently covered by health insurance. According to a report included in the May 1975 issue of the *Social Security Bulletin*, 69% of all wage and salary workers have surgical coverage, 66.5% have regular medical coverage, and only 32.6% have major medical expense coverage. Of wage and salary workers in private industry, only 46.7% have temporary disability coverage, including formal sick leave. The figures are compiled from the *Survey of Current Business* of July 1974 and represent figures for the end of 1973.[193] Clearly, these statistics ignore the other prospects for insurance but do begin to cover the costliness to individuals who are incapacitated by illness. The Committee for Economic Development has concluded that "the health-care financial system clearly has not functioned well in distributing the burden of expenditures among individuals or in allocating resources for various services according to need."[194]

Health Maintenance Organizations (HMOs) are not new. The first prepaid health care plan was established in 1929 in Elk City, Oklahoma, by a group of farmers who saw it as an extension of their farmers' cooperative. The most successful HMO, the Kaiser Permanente Medical Care Program of California, is a non-profit organization serving some 2.5 million people and has been operating since 1932. High start-up costs restrict the spread of HMOs. The problem is to have enough start-up capital to provide extensive and good care for the membership.

Federal aid for the HMO has been slow, usually limited to demonstration projects. Advantages of the system accrue from the fact that profits occur only when members are kept healthy; therefore, the quality of care is usually high. Members of HMOs probably get better preventative treatment than do other citizens, most of whom must pay for preventative care.

But all is not perfect with pre-paid group practice (PGP) schemes. "Laws now prohibiting corporate medicine or treating HMOs as in-

surance companies may severely inhibit the growth of privately funded and for-profit HMOs. Such laws currently exist in about 21 states."[195] Further, investigations into the California Health Plan were discussed in the *Washington Post*: "A key reason cited for the investigation . . . is the state's apparent inability to prosecute fraud and abuse in the prepaid health plan system properly."[196]

Another problem of the HMO is noted by W.L. Schweikert: "Although many groups, particularly the larger ones, have taken steps to eliminate clinic-like unresponsiveness to the needs of the patient, most of the complaints which they receive concern the breakdown of the doctor/patient relationship. Size alone frequently causes dissatisfaction with group practice. Groups that are too large tend to give impersonal service, become over-departmentalized, and lose the benefits found in informal consultation."[197] He continues, "In many groups, care is provided by part-time physicians. Since these doctors have both group and private-fee patients, their attention and time is split, usually to the disadvantage of the group patient."[198]

Health Insurance for the Unemployed

A final comment, prompted by hearings held in 1975. As Leonard Woodcock testified: "While the American worker is still probably the world's highest paid, he is also the world's most insecure because unfortunately his ability to protect his family with regard to health coverage depends almost entirely upon his having a job."[199] An additional area of harm might well be unemployed workers, who temporarily find themselves unable to care for their families.

Solutions for the Health Care Problems

Affirmative plans in 1977 will include certain generic features in addition to the specific mandates which correct the problems cited in the case. This section concentrates on the generic, with brief remarks on the potential mandates following. The generic categories are (1) restructuring the payment system for health care, (2) reorganizing the delivery system for health care, (3) introducing necessary elements into the existing health care system, and (4) providing incentives which would substantially modify the health care system.

Before proceeding to the categories above, one general remark regarding planks must be made. As most advanced debaters know, *specific planks of policy, when combined, should equal a system which yields the condition supported by the case arguments.* But even advanced debaters occasionally ignore one problem: only planks necessary to the resolution should be included within a plan, and *planks unnecessary to the resolutional system* should be ignored when the judge evaluates the affirmative policy. Herein, the word "necessary" means "entailed by," and therefore extratopical planks would be ignored since they would not be part of the *resolutional system*. A careful review of the initial observations about "system" included within the definition section of this analysis might aid some debaters.

Restructuring the Payment System for Health Care

Many teams will approach the problems posed by the costliness of our health care by providing for *National Health Insurance*. Such an approach means restructuring the way people pay for health care in the United States. Today, as noted in the "Problems" section of this analysis, much of the payment for care is by federal, state, and local government. Table 5 indicates the dimensions of current public payments. The fact that much of our health payment comes from purchase of private insurance policies, group health programs, or charity does not negate the possibility of a system which provides care based upon *ability to pay* in many instances.

Most systems which affirmative teams would propose would modify the underlying assumption of how care should be made available to the citizens—from *ability to pay* to *need for care*. Given the increased costs of hospitalization (Table 2), some teams may focus upon this specific aspect of the total delivery system as the point where the change should be made. In either case, the policy would stand or fall upon the basis of whether or not ability to pay should be involved in the question of obtaining health care.

One existing example of an attempt by the government to substantially modify the health care system is Medicare. Many studies have evaluated

this program; one study is strikingly vivid in its conclusions:

> The major finding of the paper has been the disparity in utilization of physicians' services among income, racial, and geographic groups—even with a uniform financing plan such as Medicare. Under Medicare, persons with incomes above $15,000 receive reimbursement for physicians' services twice that of persons with incomes below $5,000. Reimbursements for physician services are 63 percent higher for elderly whites than for persons of other races. Elderly persons in the West receive payments 60 percent above that received by elderly persons in the North Central region. Geographical and racial disparities are also present in the Medicaid program, with white recipients receiving payments for all medical services 76 percent above that received by Medicaid recipients of other races.[200]

As illustrated, absolute parity in treatment may not be a realistic goal, just as it may not be a realistic measure of the present system.

A big problem is created by restructuring based upon changing the payment system. The Medicaid system provides an example of this problem: "Medicaid abuses take place in socioeconomically deprived areas. These people feel neglected. Many had little or no medical care before the 'mills' arrived. The sudden plethora of attention by numerous physicians and the many tests—whether needed or not—are welcome changes."[201] Fraud or red-tape checking loom on the horizon of a payment scheme proposed by affirmative teams.

Another problem would be the motivation of the physicians and health professionals who would be forced to work within the system. Current profit motives would work against the system or heighten the prospect of fraud. What would be the effect upon the services rendered if the payment system allowed disparity between what patients within and patients outside of the program were charged? Clearly, debaters will have to come to grips with this sort of problem if developing a payment scheme to meet the needs developed within the case. The National Health Insurance approach, then, is viable as a mechanism to eliminate one problem but may have additional problems unless developed thoroughly.

Reorganizing the Delivery System for Health Care

Whether proposing a national program of independent HMOs, instituting a variation of the HMO concept involving one or more aspects of PGP, or developing a national hospital system, any reorganization plan will require careful effort by an affirmative team. Many vital statistics can be provided which would indicate the effectiveness of existing HMOs, both profit and non-profit. But at bas[illegible] each type is the assumption that the participating practitioners pr[illegible]re by involving themselves in the group approach. These profi[illegible] are usu[illegible]lly monetary rather than philosophical.

One study, conducted by Norman Fuller and Margaret Patera, may illustrate the data which are available. One thousand Medicaid beneficiaries in the Washington, D.C., area were placed in a PGP between 1971 and 1974. With regard to utilization of medical care, costs of care per capita,

patient satisfaction with the PGP, and drug prescriptions, improvements over direct fee-for-service payments were noted. Ambulatory physician encounter rates decreased 15%, drug utilization was down 18%, hospital admissions decreased 30%, and hospital days declined 32% after enrollment. Substantial cost savings per capita were realized. In addition, the patient satisfaction was high, both because the PGP provided dental care and because medical care seemed to be more accessible. The voluntary dropout rate was low (2.5%) and out-of-plan utilization was low, indicating acceptance of the PGP service.[202] The report even noted monetary improvement. "While over 50 cents of the D.C. Medicaid dollar goes to pay hospital costs, only 35 to 39 cents of every dollar paid for the Study Group is spent for hospital cost."[203] Clearly, such glowing reports would seem to support the prospect of combining welfare and PGP, prior evidence notwithstanding. The catch, of course, is that the pre-existing program still enjoyed the presumption of profitability.

As a DHEW report noted, "in all types of HMOs, the Health Service Plan takes the financial risk and the basic responsibility for providing health care. This gives the Plan an incentive to construct arrangements with providers in ways which minimize expensive care procedures."[204]

The obvious affirmative answer to the above problem is to *incorporate* profitability into the affirmative policy. Then, by use of evidence such as the statement in the previous DHEW report, the value of the modification should be established: "The HMO package is worth more in terms of benefits, but it is also beyond the financial reach of many poor and lower-middle income families unless subsidized health insurance can be obtained to carry part or all of its costs."[205]

Most proposals would probably incorporate a sliding scale payment formula, to keep the proposal at a reasonable cost estimate. But *all* would seem bound to incorporate some mechanism which would let profitability remain an operating motive for efficiency, the underpinning of the HMO approach.

The HMO approach, when applied to segments of a community, may create implementation problems for an affirmative team. The problems cited within the prior section of this analysis would still be relevant here. How, for example, would the proposal deal with the problem of the part-time practitioner within an HMO?

Several distinct advantages might be claimed by broadening the scope of the HMO program. Reduction of unnecessary surgery, reduced cost, preventative care, freeing physicians from administrative burdens, patient access to expert care, exchange of ideas between physicians within a program, and many more seem viable advantages.[206]

Other forms of reorganization of the delivery system are possible, of course. Modification of the hospital systems seems one viable alternative approach. So, too, does modifying the primary care system which currently neglects preventative health, a key in disease prevention. Each subset within the broader framework of the health care system of the United States provides an open option for change of our present system.

Introducing Necessary Elements into the Existing Health Care System

One physician, noting a potential answer to the problem of malpractice suits against health professionals, notes that "Peer-review systems are now developing in this country to be far more powerful than before. If the peer-review system can realize the potential for which its developers hope, it may very well provide an excellent means for critically and constructively policing the profession without the emotionally shattering tort system."[207] In most states, "medical societies are quasi-official agencies endowed with a few limited powers. As a rule, societies do not set standards for physicians. State education departments do that. Medical societies, usually organized on a county level, can merely recommend to state education departments that an erring physician's license should be revoked."[208]

Two problems, one answer: peer review. The danger implicit in the continuation of malpractice suits would appear to be excessive defensive medicine. The danger from weak medical societies might be continued unnecessary (and elective) surgery performed by unprofessional physicians.

The present system does not produce enough general practitioners. Establishing a federal training program might be the answer, and such a training program does not exist now. All sorts of additional ingredients might be introduced—from the Health Associates concept currently existing in an East Baltimore clinic under the aegis of Johns Hopkins University, through middle level practitioners who could provide the personal attention that physicians could not ever afford. Each represents an approach to resolving the problems which exist in the health care system of the United States.

The approach which attempts to introduce elements into the existing health care system should yield an advantage which is *necessary*. Clearly, all sorts of modifications might provide minor, insubstantial change. But to meet the general requirements of this particular set of propositions being debated in 1977, one would suppose that much more would be necessary. Preventative medicine is necessary if this country is to have the best health care system. Can the affirmative introduce elements into the existing health care system which would insure obtaining this condition? If so, then the condition suggested herein would be met. Multi-phasic testing procedures exist which could substantially reduce the incidence of critical illness, and the use of these screening devices is discussed elsewhere. Substantial change in the health care system might result if such systems were implemented as part of the regular preventative maintenance practiced in the United States. Similarly, immunization programs might be an important part of such preventative maintenance.

Providing Incentives Which Would Substantially Modify the Health Care System

Some affirmative teams may wish to attempt an approach which does not significantly modify the delivery system or the payment system and which does not introduce a substantially new element into the system; they may wish to infuse money into existing programs and thereby claim a

change. While doing something substantially different with such an approach, there might well be reason to believe that the dollar increase, *if substantial enough*, would actually represent a systemic change. Whether traditional judges would accept this frame of reference is a debatable subject, in and of itself.

The most obvious example of infusing money into existing programs would be in the area of research. The increased funding would clearly permit attraction of additional researchers and would thereby enhance the likelihood of discoveries which would substantially improve the health care of citizens in the United States. The various Institutes of Health exist, but the funding is not particularly substantial. However, other approaches which called for systemic changes and then provided funding would probably be more satisfying to many judges.

Some teams may combine this increased-funding approach with a quasi-rational appeal based upon faulty mechanisms. For example, the structure of the Medicare system may include elements which make it inherently flawed; therefore, a recasting of an aid program, including significantly greater funding, would be a desirable incentive to better care within the health system.

Final Remarks about Specific Mandates

The Medicare program does not provide full coverage for the aged. Many teams might wish to broaden the coverage so that there could be no question regarding the availability of care for these individuals. In addition, the staffing at nursing care homes might become a critical issue in broadening the coverage.

If malpractice suits were eliminated, and peer review systems established, licensing power would have to reside in the reviewing agency. Criminal liability would, of course, remain on the statutes.

Modifications of the Medicaid program might include the addition of such items as mental care and even such devices as eyeglasses. Dental care might be a viable addition to the current law. Care outside of hospitals and clinics might be one way to reduce costs within such programs, but potential fraud might make this provision undesirable.

Drug companies might be forced to restrict the activities of their detailmen, reduce the size of their advertising campaigns, and eliminate proliferation of minor changes in basic drugs. Such a change might create First Amendment problems, since court decisions currently protect the drug advertiser.

Use of computerized data regarding the prospect of adverse drug reactions might be the subject of a mandate when the team argues the frequency of either hospital or over-the-counter drug reactions.

Clearly, many other specific mandates might be developed on this topic. The specific comments above, relating to some of the problem areas mentioned earlier and not covered within the general discussions, are intended to stimulate the 1977 debater as *preliminary* analysis ends and the *work* begins.

Footnotes

1. "Iowa High School Forensic League Ballot" (Iowa City: The University of Iowa, 1977), p. 1.
2. Various theories of judging exist in debate. The one described here is "hypothesis testing." Two common types are the policy maker and the games theorist.
3. *Webster's New World Dictionary of the American Language* (New York: Popular Library, Inc., 1959), p. 251.
4. Ibid., p. 83.
5. Ibid., p. 114.
6. Ibid., p. 284.
7. Ibid., p. 456.
8. "Soaring Cost of Medical Care," *U.S. News and World Report* 80 (June 16, 1975): 52. Hereinafter cited as "Soaring."
9. From *The Economics of Health Care* ed. by Seymour E. Harris. Berkeley: McCutchan Publishing Corporation, 1975, p. 10. Reprinted by permission of the Publisher. Hereinafter cited as *Economics*.
10. Robert M. Gibson and Marjorie Smith Mueller, *National Health Expenditure Highlights, Fiscal Year 1976*, prepared for the U.S. Department of Health, Education, and Welfare, Research and Statistics Note. Note No. 27. HEW Publication No. (SSA) 77-11701 (Washington, D.C.: Government Printing Office, 1976), p. 2. Hereinafter cited as "National Health Expenditures."
11. Ibid., p. 3.
12. Kenneth Duff, ed., *The National Underwriter, Life and Health and Insurance Edition*, No. 33 (Cincinnati, Ohio: National Underwriters Company, August 14, 1976), p. 2. Hereinafter cited as *The National Underwriter*.
13. "Soaring," p. 52.
14. *The National Underwriter*, op. cit.
15. Lewis H. Young, ed., "The Sky's the Limit on Health Costs," *Business Week* (May 26, 1975): 74.
16. Nancy L. Worthington, "National Health Expenditures 1929-74," *Social Security Bulletin* 38 (February 1975): 3.
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18. Ibid., p. 12.
19. "National Health Expenditures," p. 3.

20. U.S. Department of Health, Education, and Welfare, *Aging* (Washington, D.C.: Government Printing Office, 1976), p. 23.
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22. "Rise of 19% in Medicare Payments by Recipients Set by U.S. Agency," *New York Times*, 1 October 1976, p. 10.
23. John H. Knowles, "The Struggle to Stay Healthy," *Time* 108 (August 9, 1976): 61.
24. Ibid.
25. *Building a National Health-Care System* (New York: Committee for Economic Development, 1973), p. 29.
26. J. F. Follmann, Jr., *Medical Care and Health Insurance* (Homewood, Illinois: Richard D. Irwin, Inc., 1963), p. 74.
27. *Building a National Health-Care System*, p. 29.
28. Allen D. Spiegel and Simon Podair, *Medicaid: Lessons for National Health Insurance* (Rockville, Maryland: Aspen Systems Corporations, 1975).
29. "Medicare and Medicaid After Ten Years," *Editorial Research Reports*, July 18, 1975, p. 527.
30. U.S. Department of Health, Education, and Welfare, *MEQC Manual-3000: Medicaid Eligibility Quality Control, Section 3, The Review Process* (Washington, D.C.: Government Printing Office, 1975), p. 10.
31. Ibid.
32. National Center for Social Statistics, *Medical Assistance (Medicaid) Financed Under Title XIX of the Social Security Act* (Washington, D.C.: Government Printing Office, 1974), p. 2.
33. Stuart Auerbach, "Medicare: The First Ten Years," *Washington Post*, 27 July 1975, p. C1.
34. Don Morphew, *Barriers to Health Care for Older Americans, Joint Hearing before Subcommittee on Health of the Elderly and Subcommittee on Long Term Care, Senate Special Committee on Aging, May 25, 1974* (Washington, D.C.: Government Printing Office, 1974), p. 1073. Hereinafter cited as *Barriers Hearings*.
35. Marilyn Schiff, July 17, 1974, *Barriers Hearings*, p. 1572.
36. U.S. Department of Health, Education, and Welfare, *Your Medicare Handbook* (Washington, D.C.: Government Printing Office, 1976), p. 9.
37. Wiley Crittenden, *Barriers Hearings*, p. 1549.
38. Lloyd E. Burton, and Hugh H. Smith, *Public Health and Community Medicine in the Allied Medical Professions* (Baltimore, Maryland: The Williams and Wilkins Company, 1975).
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40. Ibid., p. 20.
41. Ibid., p. 21.
42. The above is all paraphrased from the Lave and Lave report.
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44. Ibid.
45. National Institute of Mental Health, DHEW, *Psychiactric Bed Needs: An Analytical Review*, Publication No. Adm 75-205 (Washington, D.C.: Government Printing Office, 1975), p. 1.
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48. Ibid.
49. Ibid., p. 84.
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58. Ibid., pp. 34-36. The material herein is representative of the sort of information which would allow a debater to question the significance of a change, since a ±5% standard deviation is expected in much statistical data. If the change indicated by an opponent is less then 5% variation, then there can be no assurance that the change has, in fact, occurred.
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60. Johanna T. Dwyer and Jean Mayer, "Beyond Economics and Nutrition: The Complex Basis of Food Policy," *Science* 188 (May 9, 1975): 568.
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66. *Vitamins: Their Use and Abuse*, p. 96.
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85. Ibid., p. 6.
86. Ibid., p. 9.
87. Ibid., p. 13.
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89. Ibid., p. 14.
90. Ibid.
91. Ibid.
92. Ibid., p. 18.
93. *World Almanac: 1977*. p. 953.
94. *Current Estimates—1974*. p. 8.
95. *Statistical Abstract*. p. 87.
96. *Current Estimates—1974*. p. 21.
97. Ibid.
98. U.S. Department of Health, Education, and Welfare. *The Supply of Health Manpower* (Washington, D.C.: Government Printing Office, 1974). p. 15.
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